

**Mental Health Medication Advisory Committee Meeting**  
**Meeting Minutes, Open Session**  
**February 9, 2016 at 2 pm – 4 pm**

**MHMAC**  
Meeting Minutes  
Open Session  
HP Enterprise Services  
Capital Room  
6511 SE Forbes Ave,  
Topeka, KS 66619  
February 9, 2016

**Members Present:**

Aaron Dunkel, Deputy Secretary of KDHE/ Appointed Temporary MHMAC Chair  
Vishal Adma, MD, MS, CMQ, CPE  
Holly Cobb, NP  
Nicole Ellermeier, PharmD  
Rebecca Klingler, MD  
Charles Millhuff, DO  
Karen Moeller, PharmD, BCPP  
Taylor Porter, MD

**Members Absent:**

Susan Mosier, MD, MBA, FACS  
Brad Grinage, MD

**KDHE Staff Present:**

Liane Larson, PharmD, MPH, KDHE/DHCF  
Carol Arace, KDHE/DHCF

**MCO Representatives Present:**

Jennifer Murff, RPh – United Healthcare  
Sosunmolu Shoyinka, MD – Sunflower  
Jonalan Smith, MD – Sunflower  
William Mack, MD – Amerigroup  
Gary Haulmark – Amerigroup

**HP Staff Present:**

Karen Kluczykowski, R.Ph  
Nancy Perry, RN

**Representatives:**

Jim Baumann; Pfizer  
Barb Conant; KABC  
Monica Cuba; KDHE  
Katherine Friedebach;  
Sunflower  
Janie Huff; Takeda  
Phil King; Pfizer  
Jeffery Neshi; Takeda  
Jennifer Wilbanks;  
Otsuka

	DISCUSSION	DECISION AND/OR ACTION
<p>I. Call to Order</p> <p>A. Introductions</p> <p>B. Announcements</p>	<p><b>Call to Order:</b> 2:05pm</p> <p>Dep. Sec. Dunkel: I think we've got most everyone around the table now. As you can see, I'm not Dr. Mosier. We had an issue the other night that came up on the Senate calendar, so she's back in the State House and is working on the floor for that. I'll be chairing again which will be fun. Should be a good time.</p> <p><b>Introductions:</b></p> <p>Dep. Sec. Dunkel: For introductions, I don't think there's anybody new. Well, yes; why don't we go ahead and do introductions as we do have some folks that haven't been here. We'll start with you, Liane.</p> <p>Dr. Liane Larson: I'm Liane Larson. I'm a Pharmacist with Kansas Medicaid and I'm basically, the facilitator; I have to get everything out ahead of time for meetings and if you have any questions, let me know.</p> <p>Ms. Holly Cobb: I'm Holly Cobb. I'm a Family Nurse Practitioner and was Primary Care at Valeo and now I am a Primary Care Provider at Oasis Family Medicine.</p> <p>Dr. Taylor Porter: Taylor Porter. I'm a Psychiatrist and currently the Medical Director at Valeo in Topeka, Mental Health Center in Topeka.</p> <p>Dr. Nicole Ellermeier: Nicole Ellermeier. I'm a Pharmacist with Med Trak, a PBM in Overland Park.</p> <p>Dep. Sec. Dunkel: I'm Aaron Dunkel. I am the Deputy Secretary of Kansas Department of Health and Environment.</p> <p>Dr. Rebecca Klingler: I'm Becky Klingler. I'm a Pediatrician in Manhattan.</p> <p>Dr. Charles Millhuff: Hi. Chip Millhuff, Child Psychologist. I work at Family Service and Guidance Center.</p> <p>Dr. Vishal Adma: Dr. Vishal Adma. I'm the President of Kansas Psychiatric Society as well as I work at, as Medical Director at KVC.</p> <p>Dr. Karen Moeller: I'm Karen Moeller. I'm a Pharmacist with the School of Pharmacy and I work with the Psychiatry Unit at KU Medical Center.</p> <p>Ms. Carol Arace: I'm Carol Arace, Division of Health Care Finance, Administrative Assistant.</p>	

	<p>Dr. Jonalan Smith: I'm Jonalan Smith, a Pharmacist with Sunflower Health Plan.</p> <p>Mr. Gary Haulmark: My name is Gary Haulmark. I do government relations for Amerigroup. I'm not a clinician of any sort.</p> <p>Dr. William Mack: I'm Bill Mack. I'm the Medical Director, Behavioral Medical Director for Amerigroup.</p> <p>Ms. Murff: I'm Jennifer Murff, and I'm the United Healthcare Pharmacist.</p> <p>Dep. Sec. Dunkel: Thank you all.</p> <p><b>Announcements:</b></p> <p>Dep. Sec. Dunkel: The next agenda item we have are announcements. There are a couple things I want to cover here. One; The first thing I want to cover is just a reiteration. I know Liane has talked to the health plans, and I want to make sure everyone understands. We've had a number of comments since the last meeting about the role of the MCOs at the table and why they're here. We've had conversations and reiterated with them that, really, they're here as operational and kind of subject matter folks as we go through the conversations; not here for opinion, no 'I feels' or 'you shoulds' kind of conversation. Really here as a technical resource kind of like myself or Liane in these conversations. The decisions; the debate; the conversations should really be mainly among the committee members. So we are going to monitor that pretty closely and if we feel there is any deviation from that we will call a time out and go down that road a little bit. Just as a reiteration of kind of what the intent is and what everybody's the rules are. Again, we have had a number of comments since the last meeting about whether that was bleeding over and putting a little bit of a box around the MCO contribution to the conversation. We want to make sure everyone is on the same page and we know where we are. That's the first piece on announcements.</p> <p>The second one has to do with a suggested kind of alteration to how we do some of the activity of the committee. We wanted to kind of throw it out there and see how you felt about it. Up to this point, what we've done, predominantly, is we've brought items to the committee. You guys get them a couple weeks ahead of time with the agenda; we do the debate; we do a vote and we go on down the road. In order to have a little more input from those that aren't on the committee, for the comment type of period, because of the fact that we've treated what we've provided you guys kind of as the base line as kind of a more straw-man type of document, what we'd like to do is change that process just a little bit. We'd bring things to the committee meeting; we'd have discussion; there'd be amendments; you would vote on the recommended draft. Then what we would do we would take that back, get the final draft ready. And then basically bring it back to the next regularly scheduled meeting for a kind of final action. That way folks could see what it is that the committee came up with, not necessarily what Liane, myself, and Dr. Mosier, or whoever else has involved in looking at those originally, but really what the committee has determined to be appropriate. Have that available for comment, public viewing, public ingestion. Let them prepare comments, come back that next meeting and if folks have comments, that's fine. We'll put it in the agenda above the final vote and then,</p>	
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	<p>if not, that gives some folks on the committee also more time if there's something that you think about when you're driving home, then maybe we'll have another conversation. Kind of gives us two bites of the apple within the committee. Then we'd have our final vote and that would be what would be moving forward to DUR. While we're not going to ask for a formal vote, I'm just going to ask; is there anyone that would be contrary to that? Or doesn't see that as being appropriate? {Silence} Ok, then that's how we'll function moving forward. The ones we have on here today will be how we look at those.</p> <p>Anybody else have any announcements they'd like to go over?</p> <p>Dr. Larson: The one that we generally make just to cover all bases, I know that last time, is no parking beyond the HP building to the south side, I know a lot of people had to move vehicles last time, so if anybody is parked there, there is potential to get towing. That's the only one I have.</p> <p>Dr. Adma: I do want to bring up something.</p> <p>Dep. Sec. Dunkel: Yes.</p> <p>Dr. Adma: On the agenda, we do have a Preferred Prescriber Status as one of the agenda items. May I ask the Chairman to see if we discuss that first before we go on to the rest? Are there any objections to that?</p> <p>Dep. Sec. Dunkel: Are there any objections to discussing that between items A and B of Old Business?</p> <p>{Silence}</p> <p>Dep. Sec. Dunkel: Ok. We'll make that adjustment to the agenda.</p>	
<p>II. Old Business</p> <p>A. Review and Approval of December 9, 2015 Meeting Minutes</p>	<p>Dep. Sec. Dunkel: So, seeing no other announcements or comments we'll go ahead and move into Old Business.</p> <p><b>Board Discussion:</b></p> <p>Dep. Sec. Dunkel: Review and approval of the December 9, 2015 meeting minutes. Has everyone had an opportunity to review minutes? Does anyone have adjustments or edits?</p> <p>Dr. Klingler: I gave Liane one adjustment on page 46. 'Neurology' should replace the word 'Urology'.</p> <p>Dr. Larson: And we did make that change.</p> <p>Dep. Sec. Dunkel: With that edit made, are there any other? Seeing none; can we get a motion to approve?</p> <p>Dr. Ellermeier: I'll motion.</p>	<p>Dr. Ellermeier made the motion to accept the minutes as amended.</p> <p>Dr. Klingler seconded the motion.</p> <p>The MHMAC Minutes for the December 9, 2015 meeting were approved unanimously.</p>

	<p>Dr. Klingler: Second.</p> <p>Dep. Sec. Dunkel: Second? Dr. Klingler.</p> <p>Dep. Sec. Dunkel: All in favor please say ‘Aye’. {Many committee members are heard to say ‘Aye’ .}</p> <p>Dep. Sec. Dunkel: All those opposed - same sign. {Silence.}</p> <p>Dep. Sec. Dunkel: Thank you.</p>	
<p>IV. Process Improvement Initiatives - For informational purposes only</p> <p>A. Preferred Prescriber Status</p> <p>1. Committee Discussion</p>	<p>Dep. Sec. Dunkel: We’ll move item IV. Process Improvement Initiatives – Preferred Prescriber Status then up in the agenda and have that conversation. Liane?</p> <p>Dr. Larson: I don’t specifically have anything to present on this particular one. I might just note that it’s a continuation of the discussion that we had the last time.</p> <p><b>Board Discussion:</b></p> <p>Dr. Adma: So, when we met last time and talked about this, the reason why this came up is, there are prescribers in the State; I think the MCOs had a question of, um, the medications being prescribed by Primary Care Physicians and people with not as much training and one of the things that was brought up is what if there was a preferred provider status attached to a prescriber based on the prescribing habits or based on the kind of patients that they treat on a regular basis. So if that were to be attached to a preferred pres...er, those clinicians attached with a preferred provider status they might not be doing as many prior authorizations as they would normally do. So with that in mind, that would change the game plan in terms of how we, as committee members, might look at these situations. Because we know that there are going to be prescribers in our community who do treat these tough patients and if we could figure out a way to come up with a plan to have preferred prescriber status attached to the prescribers and we can come up with a criteria for that, then that might be one thing to think about it.</p> <p>Dep. Sec. Dunkel: Thoughts?</p> <p>Dr. Porter: I was just wondering, we were talking earlier about the makeup of the committee, and our interaction with the MCOs here. I’m pretty sure, we might suggest our thoughts but I think such a thing would be up to them. Cause that wouldn’t be actually under the privy of what we’re looking at regarding the prior auth process. But I think it would be; I think it’s a great idea, but I don’t know how, maybe they want our advice but I don’t think we can tell them what to do about that, can we?</p>	<p>For informational purposes only.</p>

Dep Sec. Dunkel: Right. What we've looked at on the prescriber status is that this group, what we want to do is bring the policy, one policy that will overlay on all 3 MCOs, that's the agency intention. What we want to do is to have the conversation with this group as to; what we might want to have in that policy; how it might move forward. Again, I think that there's two big components, well, there's three components really, two of the bigger ones, one of them is by provider population which are who we are looking at. As a subset of that if we are looking at folks that are Psychiatrists and folks that have credentials that are beyond that, that we talked about the last time, that are psychology or psychiatry related. How do we deal with that? Do we suggest rolling them all into one? Do we suggest tier rolling where it's Psychiatrists first and then these next groups as we kind of get experience with it? That's one piece. And then again the timing of that also is a part of that. And then the second piece is the criteria; what qualifies somebody for preferred prescriber status and then what allows them to maintain or lose that status. And what those criteria should look like. Those are the two big pieces. And of course the thing that underlines all of it is the timing of what we're going to do. Now I'll tell you one of the things we'll talk about later, at the end of the agenda is sub 'B' under Process Improvement Initiatives, which is the DUR approved criteria timeline, as a little preview, one of the first ones that went through the DUR, at their last meeting, we are looking at possibly like a May 1<sup>st</sup> implementation. So I think that from an agency standpoint at least, what we would like to see is a conversation that'll let us, and then working with the MCOs, to actually have kind of a first round/first tier of preferred prescribers to have that system available for them by the time we get to May 1. If not, very soon after. So, that's kind of what we're thinking as an agency. Again, what we talked about last time; we had our fifteen (15) minutes, so we were just really throwing a lot of ideas out there. But I think having the conversation, so what I would suggest is maybe we have the conversation around the provider populations first, and get you guys input on that.

Dr. Adma: Ok.

Dep. Sec. Dunkel: I know you've had some more time to think about it. I know that we've had conversations with folks outside of this group. We've sent out to CMHCs a little bit and said, 'What do you think?' and they've given additional feedback on like APRN staff within the mental health centers. So, with that, and knowing that we won't roll out to the entire provider population at one time, if we were to look at a first tier, what would the body suggestions be, I guess?

Dr. Adma: Chip, your thoughts?

Dr. Millhuff: Can you explain; the first tier would be being what?

Dep. Sec. Dunkel: Those would be the ones we would be looking at rolling out in the first wave. So folks we'd probably look at May to July of this year.

	<p>Dr. Klingler: It's kind of an automatic preferred status?</p> <p>Dep. Sec. Dunkel: I think we'd want criteria conversations after that. It might be, even within that, here's Psychiatrists and here's the kind of criteria that would be appropriate for them because we have a higher level of trust that they are doing it correctly. But still, like this provider/criteria combination, the first part of that was just having a conversation around who's going to be in that first group, because obviously it isn't going to be everybody. Is it Psychiatrists only? Is it Psychiatrists and related medical staff within the mental health centers? Does it include folks that have, like pediatric?</p> <p>Dr. Klingler: Behavioral developmental.</p> <p>Dr. Moeller: What do they accompany? Like all of the things we have voted on? Or would there be, like just for children? They have to be board certified? Child and Adolescent Psychiatry?</p> <p>Dr. Adma: Which is the?</p> <p>Dr. Millhuff: Right and in looking in at the psychotic use in children we were talking about it being prescribed only by certain individuals. To me it seems like if your board eligible or board certified in child psychiatry, pediatric neurology I'm just speaking for the pediatric population; developmental pediatric. That's just off the top of my head and then if you're in, the other thing that we mentioned with the anti-psychotic medicines in children was the idea that you would be under the direct supervision for a nurse practitioner and so forth.</p> <p>Dr. Moeller: Would first tier be like? Would you want more like the MD's and the DO's? Like to me that would I – like a pharmacist would be thinking.</p> <p>Dr. Millhuff: I am kinda thinking like...</p> <p>Dr. Moeller: First tier and see how that goes and then get into the secondary practitioners.</p> <p>Dr. Millhuff: I'm just thinking the setting I work in, community mental health center. I know the nurse practitioners are working at a very heavy pace as the physicians are and I am wondering really if we are working in the same clinic together, there supervised weekly. I see what you are saying, but practically speaking.</p> <p>Dr. Moeller: I do know that they are probably seeing a lot more patients. Sometimes more patients cause they have to get them in and out, and so.</p>	
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	<p>Dr. Adma: The only comment after that, is obviously the amount of supervision varies from one mental health facility to another. One physician to another physician. It all depends on that availability that they might have.</p> <p>Dr. Porter: I think the amount of supervision, amount of responsibility kind of varies predictability based on how urban the setting. I think the NPs the further you get from training center or from a larger city are taking on more responsibility, and there's less oversight probably overall.</p> <p>Dr. Adma: Are there any models out there that the MCO's are using in terms of preferred provider status, in terms of something you guys have talked about last time? Just feedback?</p> <p>Dr. Smith: I think like psychiatrists make natural sense to me. For first round I mean, not only, you can look at quality scores but naturally education and residency training especially when you have child psychiatry level of only a year in a certain pediatric population. Naturally that would probably set you up for, you know, exceptional provider status easier than, you know a certain practitioner can meet that level but has done that more on the job training for which practitioner she or he's worked with.</p> <p>Ms. Cobb: I do think of places like Valeo; who have, they are all nurse practitioners with one exception and so that's a lot of patients they serve so for good customer service and not to take roadblocks out of the way, think that might be something to consider too.</p> <p>Dr. Porter: It also gets to how much work is going to come with these things and I think that we determined what's going to be asked for the child monitoring, is that actually not a phone call and we still have kind of put off what the prior authorization is going to look like. What do we recommend about that? So, a lot of the child stuff was about monitoring labs and was not supposed to involve phone call or something that would keep them away from patients that could be something/information that could be sent by support staff was my understanding. Then we get back to the numbers of actual outliers on some of the other ones and the numbers were fairly low on the three anti-psychotics etc that the actual volume wouldn't seem to be that high.</p> <p>Dr. Ellermeier: I would agree, I think that a lot of what we already looked at and approved the volume is not very high as far as the number of patients and the number of PA's, it's really the outliers. So I don't know how broad we would need to go at this point with a preferred prescriber status because we're already are kind of just capturing outliers.</p> <p>Dr. Adma: So is it safe to say that for a maybe we can start out with a board certified psychiatrist for pediatric populations, board certified child psychiatrist and developmental.</p> <p>Dr. Klingler: Developmental Peds, and Peds neurology.</p>	
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	<p>Dr. Adma: At least in a broad sense.</p> <p>Dr. Porter: I was joking about it last time but I also think that one thing that was surprising to all of us was that there was some practice patterns that none of us could really understand, some prescribing things and think there still has to be a way, there already is through the Kansas State Board of Healing Arts. Ways that somebody who is really out of line regardless of their certification can be – put pressure on them. Because what we heard from our consultants here was that when they send out these reminder letters they say hey this looks weird, they are just ignored.</p> <p>Dep. Sec. Dunkel: Well one of the conversations we had internally, Dr. Porter, is to really utilize the retrospective a little bit more, and have and work with the MCOs more, especially as we role things out, that if we do see, even if we have folks who are preferred for prescriber status, if they go look then find you know fifty or sixty prescription patterns, individual patient patterns and look odd, then there nothing keeping us or them for reaching back in and saying ‘hey can you, we’ve have had some questions come up’.</p> <p>Dr. Porter: That would actually be leverage, hey if you...</p> <p>Dep. Sec. Dunkel: Exactly.</p> <p>Dr. Porter: You better conform if you want to keep your status.</p> <p>Dep. Sec. Dunkel: And it seems that would be; that’s probably something we will see in the draft of the retention of status type of component. Because the last thing we want to do is have someone who is out there that is a preferred prescriber that’s doing bad things.</p> <p>Dr. Adma: So based on the discussion that we had so far; are we saying we need to come up with a policy related to this?</p> <p>Dep. Sec. Dunkel: What we’re really looking for is kind of guidelines on what you would like to see in the policy and then we can put together a policy for review. But if we are looking, right now what I am hearing is really the psychiatrist, board certified and the ones that are certified in the pediatric components of that, hope I got all the right titles for that for you guys. Making sure we have everybody is encompassed at least in round one.</p> <p>Ms. Cobb: Just to make sure I’m understanding, when we prior auth, this first round would be required for anybody except with those credentials, when we implement this. Is that correct?</p>	
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	<p>Dep. Sec. Dunkel: Yeah and then again we still need to have a little bit of conversation with other criteria that disqualify people for the first round even. But as far as, assuming there's nothing that would disqualify them. Then yeah.</p> <p>Ms. Cobb: When would it, so this first round, when would it be looked at again? Because I am concerned about the large, large numbers of nurse practitioners that do a great job for mental health that this barrier would be put up.</p> <p>Dep. Sec. Dunkel: And our intent would be that wouldn't be; were talking like six months. Where hoping not to have to go very long. I think it's just a matter of when we actually get implementation, seeing how that works.</p> <p>Ms. Cobb: I guess if this was, I would want/ask that something be put in the policy about a timeline when it was looked at again and if this worked appropriately then.</p> <p>Dr. Porter: Seems like a key thing would be to 'how you would earn your way into the status'?</p> <p>Dr. Adma: And maybe feedback from you. Say if they had five or ten, could be years of experience? Something like that.</p> <p>Ms. Cobb: And the prescribing patterns I mean, you know we could probably get to look at large sample and say ok these good prescribing patterns are already there so why not go for preferred status?</p> <p>Dr. Millhuff: Or if you work in, or if what you do primarily is psychiatry.</p> <p>Ms. Cobb: Exactly, that's what I'm saying, not for primary care.</p> <p>Dr. Millhuff: In the mental health center and this is all you do pretty much.</p> <p>Dr. Klingler: The things that are getting Prior Authed are the outliers though, right? It's not that you're gonna get flagged for prescribing Fluoxetine, I mean it's because your prescribing three or four things together – those combinations we talked about and I don't really have a problem with limiting who can prescribe those outlining kind of things. I don't think it affects single drug therapy or the things are being used in dose appropriate ranges, it's the outliers that are higher doses, multi drug therapy, so I don't really think that we have to broaden it when we are talking about providers that are going to provide more complex evaluation and treatment.</p> <p>Dr. Ellermeier: I would agree and as far as the criteria goes, as for who would be eligible within whatever prescriber type we decide on. I think that we should not just look at years of experience, but maybe look at if</p>	
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	<p>they are having prior authorizations and they're at like a 99% approval rate on the things that they are prescribing that are out of what we; you know; that are outliers and they always have information to back that up and they kind of have a good approval percentage, maybe those are ones that get it added to a preferred status. They're always able to support what they are doing.</p> <p>Dr. Moeller: Cause that, I know years of experience, I mean you can have, cause I was thinking that too with the psychiatrists, I mean I can see that people going out of residency that are excellent; then you can see some that aren't. So I mean, I think years of experience is hard to kind of judge, sometimes.</p> <p>Dr. Smith: One of the questions we had about how this would be operationalized, was basically, your point, Dr. Klingler, a lot of these are outlier situations so would you want a gold card, if someone reaches gold card status do you want that to apply to all the policies or just certain ones; so would we apply that to three or more anti-psychotics in adults? Gold card provider gets excluded from that or would you be looking at just certain policies? Naturally the one with the kids under 13 just because that's not necessarily a quality related one. It's more of everybody will get it, just make sure you monitor these things. Don't know what you guys thought on that, but that's what we were thinking about from our perspective.</p> <p>Dr. Klingler: I guess my thought is that those gold card providers would take over all those policies, I mean, would be approved for all those policies.</p> <p>Dr. Ellermeier: Also, I think for what we've approved so far I would agree but perhaps it's something that as were looking at each individual policy it's something like should it apply or not, it shouldn't be a, you know, an hour discussion on what qualifies as a preferred prescriber once we have that ironed out but really does the preferred prescriber status apply or not to this policy.</p> <p>Dr. Moeller: I would say for like the children under five antipsychotics; now, I know there's a lot of psychiatrists that are board certified in child and adolescent that may work with five years old, so that's something, you know, first I would think it should only be for the, you know, the child and adolescents but then I think there so limited amount of you guys throughout the country. You might have several that aren't specialized, so.</p> <p>Dr. Adam: So as we've come up with these; are there models that anybody is aware of? From any other states? Any models like this for provider's status?</p> <p>Dr. Millhuff: I raised the issue last time about this Amerigroup program in Tennessee and how you would go through a cycle of educational pharmacology thing, which would earn you that status if you're a primary care physician. I haven't heard any more about that but it seemed like a model that would make sense for someone who maybe is a primary care that does want to do a lot of psychiatry work because I really also think that um,</p>	
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	<p>my hope is that um, that one of the primary things that happens from the work this committee is um, not just that we are um, reinforcing safer prescribing practices, but educating people.</p> <p>Dr. Adma: True.</p> <p>Dr. Klingler: Well I think a model like that would be very interesting. The American Academy of Pediatrics is doing more and more literature and training on the role of primary care pediatricians in psychiatry because there's so few pediatric and adolescent psychiatrists and behavioral developmental Peds providers available and so I think that if there was a model like that, can be very useful especially in a rural state where we have a lot of family practice Docs, and a lot of pediatricians that are kind of out there without support from mental health professionals.</p> <p>Dr. Mack: I didn't look into that directly. I think Lisa Todd might have, and she's not here today, so I'll find out before the next meeting or get information to you before that, even. I don't have that information today.</p> <p>Dr. Moeller: I think the good first tier, sounds like we're all similar to on the same page? Board certified or say 'board eligible'?</p> <p>Dr. Millhuff: I am just thinking of a brand new, well maybe not. I'm just thinking sometimes you've got a fellow coming out of child training and they are at the top of their, they don't have the experience, but they really know... It would be really difficult to come out of training and not be restricted right out of the chute, you know, with not having the experience.</p> <p>Dr. Klingler: How long before you can sit before your boards?</p> <p>Dr. Millhuff: I think it is within the first year. If we are going; I don't want to debate this too much.</p> <p>Dr. Klingler: Board eligible makes sense.</p> <p>Dr. Moeller: It's the first tier though, too. You know, it's not...</p> <p>Porter: I don't know what Brad or Dr. Adma would think, but I think maybe for adult psychiatrists it's just not bad to have first tier of board certified. I'm not saying it should always to be that, as different from the child training, to spend another one or two years in training on a specific subject I think sometimes, and I'm not saying if you don't have your certification you can't be a good doctor but I don't think there is anything wrong with that, making that a first criteria, it actually gives people slight encouragement to continue their efforts to get their certification; again for the adult. I don't know about the other.</p> <p>Dr. Adma: I agree</p>	
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	<p>Dr. Moeller: Don't they also get board certified during their first adult psych...?</p> <p>Dr. Millhuff: You got to get your general psychiatry certification first, then you can sit for your child ...</p> <p>Dr. Smith: So they already meet that.</p> <p>Dr. Moeller: They will probably already have their adult...</p> <p>Dr. Millhuff: That's a good point.</p> <p>Dr. Moeller: I was just thinking that.</p> <p>Ms. Cobb: I would be curious on knowing the thoughts on the committee for, nurse practitioners that are mentally health certified that work in a mental health facility, specifically. I'd just would be curious on your thoughts on this.</p> <p>Dr. Adma: They have additional certification right?</p> <p>Ms. Cobb: Yes. Yes.</p> <p>Dr. Adma: What's it called?</p> <p>Ms. Cobb: Mental Health Certification with additional training. I think, I don't know how many of the nurse practitioners at Valeo have that. I assume probably all of them.</p> <p>Dr. Porter: I think everybody does now. I think you need that for Medicare. Use to be you didn't need it.</p> <p>Dr. Moeller: How much? What's the training, like the requirements?</p> <p>Ms. Cobb: Um, you know, hour wise I don't know if you have already had your, um, practitioner, practitioner degree, I think you can probably do it in eighteen months. Depending, yeah.</p> <p>Dr. Porter: Its um, I don't get it exactly right but I have helped a lot of people go through it. They have to go back through and do pharmacology and physiology, pretty extensive didactics and something like five hundred hours of clinical, um, it's quite a bit, it's not so much as residency. But its uh, it's quite a lot of time on that, to get that certification but.</p>	
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	<p>Dr. Smith: When you get that, are you able to update your NPI. To show that certification? I only ask that because that would be how would be able to tell if someone was certified.</p> <p>Ms. Cobb: No.</p> <p>Dr. Porter: I know it takes you from not able to bill Medicare, to be able to bill Medicare.</p> <p>Ms. Cobb: So there's, yeah.</p> <p>Dep. Sec. Dunkel: We can do some research on that, I think.</p> <p>Dr. Adma: Another thing to add to that is obviously in Western, Kansas. We have board certified general psychiatrist but still be seeing kids. So what do we do with that? So here we are saying you need to be board certified in children in order to get that, so.</p> <p>Dr. Moeller: I think we are generalizing it to board certified psychiatrist and then adding the child behaviorists.</p> <p>Dr. Klinger: Developmental Peds and Neurology.</p> <p>Dr. Moeller: And maybe they are specifically only added to ones that apply to children. But anybody that the psychiatrist board certified can do the children and adult. That was my concern too.</p> <p>Dr. Adma: Ok.</p> <p>Dep. Sec. Dunkel: Ok. So, from the committee's prospective then, let's assume that we're, we'll go through and do a tiering of the group we just said first, the APRN's probably second, and then a third tier that would be like more your general practitioners. There's a lot more conversation around that we need to have. Whether we need to have require something like something we were talking about like Tennessee Amerigroup, where they had to go out prove and certain level of training, a certain level of expertise, So it sounds like we've got a pretty decent.</p> <p>Dr. Porter: I would suggest that if we, do decide that the criteria is board certified general psychiatry, board eligible psychiatrist, that the second group, in addition to psychiatric APRN, should probably be the non, the board eligible general psychiatrists.</p> <p>Dep. Sec. Dunkel: So then focusing kind of, at least for this part of the conversation on that first tier is there anything that we, that you guys would want to see in the way of criteria if there was a determination made,</p>	
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	<p>or, criteria that would be used to make the determination that maybe somebody should not be included in the preferred prescriber group?</p> <p>Dr. Ellermeier: Are the MCO's currently doing any um, like retrospective education pieces out to provider's right now for mental health?</p> <p>Dr. Smith: Yes.</p> <p>Dr. Ellermeier: Um perhaps um that's looked at, if that prescriber is not willing to participate in those programs.</p> <p>Dr. Klingler: I guess I would take a different take on that, that someone already brought up that inappropriate providers are eligible to be reviewed by the State Board of Healing Arts and I think that's a more appropriate place for review than an insurance company to be honest. I, I think, that we want to keep those kind reviews at a different level.</p> <p>Dr. Porter: We still have this idea though that somewhere in-between or maybe overlapping would be this preferred provider status. We don't want it, I don't think we want it to be permanent. You know, like you can't have it taken away by, and so that would be something that would be under this discussion although that's always been there and I am sometimes surprised when we see some of the things we heard about from the very first time we went to the hearings, that, that didn't result in a, some kind of report to the Board of Healing Arts.</p> <p>Dr. Moeller: That's what I was going to ask, who reports it?</p> <p>Dr. Porter: Anybody.</p> <p>Dr. Moeller: I mean, I know a Physician could, but how am I going to know you're doing three or more anti-psychotic regularly and you know you got this gold card, you know, how is the patient gonna know that this is not appropriate to report it to the Board of Healing Arts? I can't see those as narcotics and things getting.</p> <p>Dr. Ellermeier: I also think that those are scenarios where we haven't said that it always wrong to do those, but they should have rational, which is why they should.</p> <p>Dr. Moeller: If we just give a blanket, then these proposals.</p> <p>Dr. Ellermeier: Then there is no intervention. I still feel very strongly that it shouldn't just be from day one that there is a preferred prescribed status but rather it's after three or six months worth of data has been collected, to see what the MCOs are getting back as far as requests.</p>	
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	<p>Dr. Millhuff: Well, I have a question for the MCOs. I mean if you've got a, if you're doing these reviews and it goes to doc-to-doc review or whatever; I mean, if you get an accumulation of reviews where it just isn't making good clinical sense; I mean, would it maybe be, would the ball be in your court to maybe, sort of pull the status?</p> <p>Dr. Ellermeier: But if they're never triggered for a PA, they're never required to do that peer-to-peer. So if they have prescriber preferred status from day one they're never triggered to do that.</p> <p>Dr. Millhuff: Right, so is, do you have to have a PA process to be able to call upon a doc that seems to be prescribing a little bit, you know, a little off track?</p> <p>Mr. Haulmark: I think we would, from our companies prospective, legal prospective, we'd say yes. Because the statutes in place now, yes.</p> <p>Dr. Smith: I mean, we do a lot of like you said retrospective stuff already, and some prescribers aren't willing to engage in that. But many are, and they take it really well. I mean, I think, Dr. Porter brought a letter he got from somewhere at one of the early meetings and said "Hey, this was helpful. It didn't change my mind but I engaged here." So I mean we defiantly have some of that retrospective but, I mean, yeah, some of that data exists.</p> <p>Dr. Klinger: But don't you as a company, if you have a concern about a physician, you just don't contract with them again? I mean if we have concerns about you as an insurance company we just don't contract with you again.</p> <p>Dr. Smith: It's a little complicated with Medicaid like with any of the provider statutes and things like that. The termination process is very difficult and obviously not something we want to do. We don't want to do auto referrals to the Board of Healing Arts. We'd rather have some tools that are, you know, different than, you know, 'hey, we think this person should have sanctions on their license' I guess.</p> <p>Dep. Sec. Dunkel: I think if we set it up in policy the right way, we don't have to do retro. Basically give the MCO's an avenue to be able to do the retrospective and have something where would be, you know, ok we're seeing that you are providing 3 antipsychotics across 25 % of your patient load and that doesn't seem quite right. And they go and when they do the retrospective they could always bring, try to set up in the policies, they bring it to us and say 'look here's what we are finding this provider seems to be way out of balance'. Then allow for a process that then would allow us to do, to discontinue the preferred provider status for certain folks. Then again part of this is we're trying to make sure that we don't get in the way of good care and then the back side of the reason, I think why we are all here now, is we are trying to prevent folks that are providing bad care. And so we can mitigate that, so I'd hate to, I think that whatever we have in the</p>	
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	<p>policy is going to have to have something that will allow us, cause really the only the only care we have in this deal for the most part is being able to pull that preferred provider status and making them go through on a case by case basis and do the PA, if we think they are a bad actor.</p> <p>Dr. Millhuff: What I was thinking about as you were talking about this was, we have these different tiers of providers among all of us, also was thinking about different tiers of these prescribing limits. And when we went over anti-psychotic limits for adults, those doses were pretty high in my opinion and as I am preparing for today's topics, on stimulants I think about what would be a tier for primary care vs. a tier for someone that's getting the more complicated. It almost seems like we should have two different tiers and I agree with what Nicole is saying, that we should, even if you have the so called gold card, there should be limits out there at some point that would trigger review. I think that still makes sense but that you wouldn't get triggered for the stuff that would be maybe the limits set for primary care.</p> <p>Dep. Sec. Dunkel: And we have had some good conversations in that, internally, about how we might operationalize that and it makes no sense to us to go through and whether it's the dosing limits or whether it's the number of meds you can give a four year or whatever. So I really think we would be open to that, to having that conversation. What we set with criteria, we have done so far, we have that base line of the high level of provider and even with the high level provider we shouldn't even go pass without some creditable review.</p> <p>Dr. Porter: I was thinking a little bit more about what Holly said about the NPs and the mental health setting and the psychiatrist provides protocol, the collaborative practices agreements, with the number of NPs. I think, and given that these are really pretty liberal, for the adult side, pretty liberal guidelines we're looking at, or limits we're looking at, the doses are pretty high and the three anti-psychotics, the nightmare scenario where they have just come out of the State hospital on three anti-psychotics and they can't get it and you don't know them enough to fill out a PA. We've talked, we turned it to sixty days which should be enough time to kind of gather that information. I have to say, I think it's probably, and I don't know if we need a preferred provider status or not but I think it's okay to start out. I don't mind the NPs I have needing to answer, if they have cases like needing to explain it. I would actually say that if I was somehow on protocol with other psychiatrists, but I am not. So I guess I would put some thought into it and I, I think if we do would go with that, as much as a love my colleagues I would support them being considered second or keeping not preferred status for that group.</p> <p>Ms. Cobb: I couldn't help think about it, just knowing all the NPs in adult, I, you know, don't know, you know, child and adolescent as much, but in an adult mental health facility.</p> <p>Dr. Porter: Is this something about our criteria are actually pretty</p> <p>Dr. Moeller: They're very liberal.</p>	
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	<p>Dr. Porter: This won't happen that often, I think it would be good for it to be questioned, I think when it happens.</p> <p>Dr. Moeller: I mean, even physicians. And you've seen physicians and four antipsychotics. And your like, well, you know. They are liberal.</p> <p>Dr. Porter: There is a little, there is an education component that we talked about that has some value.</p> <p>Dr. Moeller: I do like Nicole's, kind of, idea, you know, in retrospective. I don't know, maybe even before it's implemented. You know, if preferred, you know, this one physician has maybe triggered 15% prior auths, I don't know how that would work.</p> <p>Dep. Sec. Dunkel: Let me ask the MCOs. If we wanted, I know we could get it from our data, but it might be easier getting it from your subsets, but, looking at the number of providers in the classification of providers that would bounce above the criteria that's been offered by the DUR already, can we then get reports like that from you guys?</p> <p>Dr. Smith: The criteria you've approved like the type of being an outlier, I mean it's like you have 1% of the claims for most of these. There's one that's is not, which is the anti-psychotics for the kids under 13; not just for the extra monitoring and things like that, but there's a lot of kids that are going to qualify for that one as opposed to you know, three or more psychotics that's very different. So I mean that one would clearly make sense from a PA burden, things like that, you know.</p> <p>Dr. Porter: But again, I wasn't clear about this one earlier in the meeting that, that the under 13 kid is not, the criteria doesn't say contact the MCO. It says provide data about monitoring and stuff like that.</p> <p>Dep. Sec. Dunkel: So I guess if you guys could pull the ones that are more, just that are really strictly no more than 3 for 60 days kind of stuff. If you can pool that information. Break out by provider type. Just real raw, not real high level numbers. And then on the ones where have the metabolic, you can match those up against whether or not they had a claim against a lab that would qualify, first components that. We can basically weed out the ones that have qualifying lab codes in their background, in their prior year worth of claims history. That might give us an idea of what that world might really look like.</p> <p>Dr. Smith: Do you want then the prescribers more, would be more towards the gold card? Or the ones that would be not towards the gold card?</p> <p>Dunkel: What I want to know is how many</p>	
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	<p>Dr. Smith: That met the good quality?</p> <p>Dep. Sec. Dunkel: What we want to know is how many. What's the universe where talking about? So if you had</p> <p>Dr. Adma: How many of those outliers are qualified child psychologists? Board certified psychologists, Nurse Practitioners, whatever.</p> <p>Dep. Sec. Dunkel: Yes and the LRP side, that piece would be awesome.</p> <p>Dr. Klingler: And will that Jonalan, like, I am a primary for three kids that see Chip. I do their labs every year when they do their well child checkup, and then fax them to him because it's easier to do the labs when they're in Manhattan than Topeka. So will that still show up and give him good credit for having ordered, shown, those labs?</p> <p>Dr. Smith: Yeah.</p> <p>Dr. Klingler: He's not ordering, I am, but there because of the medications those kids are on through him.</p> <p>Dr. Smith: the Yeah the way we pull data, and probably the same way Liane pulls her data for these meetings, it'd be based on, it would be attributed to him because he wrote the script. But as long as he got; the lab work was drawn it won't matter who ordered it.</p> <p>Dr. Klingler: Ok.</p> <p>Dr. Smith: That will be attributed to the patient not the provider.</p> <p>Dr. Klingler: Ok. So it will still show he had good prescribing practices?</p> <p>Dr. Smith: Prescribed for a member who Chip wrote a script for.</p> <p>Dr. Larson: All the data that we provided in the past, it doesn't matter who, it actually doesn't matter who ordered which one, we just look, literally, for the code for the claim that was accomplished.</p> <p>Dr. Klingler: Ok.</p> <p>Dr. Millhuff: And when you're looking at the lab, are you looking at specifically at fasting? Blood glucose and lipid profiles?</p>	
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	<p>Dr. Smith: The ones we pulled and Jennifer pulled some data too, it was really open. It was like any sort of metabolic screening.</p> <p>Dr. Millhuff: I would be curious how many people would really fall within the range of, you know, what is recommended, which is fasting and blood glucose and lipid profile.</p> <p>Dr. Smith: Yeah, we just pulled really high level.</p> <p>Dr. Larson: Could be pulled according to the approved criteria which basically however you would pull it for a PA whatever lab codes you would allow for that PA, those would be the lab codes used to pull the data.</p> <p>Dr. Adma: What are the percentage in terms of ordering the metabolics? Do you know what percentage of patients?</p> <p>Dr. Smith: We pulled it. See if I can find it. Do you remember, Jennifer? I know you guys pulled some really good lab data on that one.</p> <p>Ms. Murff: Yeah.</p> <p>Dr. Smith: It's like 40 or 60% I can't remember which was adherent and which was non-adherent.</p> <p>Ms. Murff: But yeah, it was definitely significant enough to be a concern the number of kids that didn't have the appropriate labs on file. So and we didn't, and I have the data, I just don't have it calculated out. But we didn't look at specialty at that, at that point and I have looked at some of the outliers data. So and like the stimulants we're looking at today and have looked at some numbers, and just in the outliers, and the biggest percent of our prescribers are Nurse Practitioners but they do seem to have the mental health specialty. So that's where we see most of the prescribing for the kids but we also see family practice and, and, you know, that's one of the challenges there, seeing if there is an initial prescribing in consultation with or initially by a psychiatrist. So there are some challenges I think in operationalizing. Getting all of that data and making sure that it's, it's solid across, it's apples to apples for, for all three MCO's. So when we come up with that, that list of those prescribers and when we, we determine you know which, whose going to be on that exceptional prescriber list and I think that's one of the concerns too with some of the policies that might, you know, where, the doses or, but anyway yeah we can definitely get that information it's just somewhat challenging to get all of it together but it would be at patient level. It would be based on the patient with the claim and then looking at labs on file. Looking at the diagnosis. We have been looking for diagnosis on file too making sure that there's a mental behavioral health diagnoses associated.</p> <p>Dr. Adma: One more thing on the metabolics, as you look at the data, sometimes if they're admitted to a hospital, a residential program, cause it's a per diem rate and they might have gone done the test but they</p>	
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	<p>don't get the credit because it's not done on an outpatient basis so I don't know if what percentage of that is because of them being in a facility.</p> <p>Dr. Ellermeier: But I think that's the point of the PA is to just have them check that they have made that attempt. Since it can be captured.</p> <p>Ms. Murff: And that's a good point too, because also yeah, delay in time for us to have that data available and that's one of the issues with the level of care also is you know, if it's the situation where it's not, it's no longer primary but being escalated to specialist level and for us to actually have that data, to be aware of that, it would be, the prior auth would be faster.</p> <p>Dr. Adma: It might be a good idea because some of these patients were talking about, you know, patients on multiple medications and all and more likely than not they might hospitalizations and all right? Might be a good idea to have it in your system that hospitalize part of the DUR process does require some of this stuff so it's already in your system as you are talking about.</p> <p>Dep. Sec. Dunkel: So I think we've got a pretty good idea on, on population break downs. I think we have good things on criteria. We are about an hour into our two hour agenda, so, what I would suggest now, is we kind of move on and get into the opening of business if that is okay with everybody. And what we'll do we'll work with the MCO's to get the data. We'll work with kind of drafting up something to actually look at around the gold card, and plan on having that back on the next agenda. Thank you guys very much.</p>	
<p>II. Old Business</p> <p>B. Prior Authorization Criteria</p> <p>1. Use of Multiple Concurrent Antipsychotics – Review proposed clinical criteria for adults and children prescribed multiple concurrent antipsychotic drugs.</p>	<p><b>Clinical Public Comment:</b> - No requests were received.</p> <p>Dep. Sec. Dunkel: That old business being prior authorization criteria. The use of alternate/current anti-psychotics and I will turn over to Liane for update.</p> <p>Dr. Larson: We did take the criteria that the committee came up with to DUR last month and 6 of the 7 criteria passed through. One of them that was sent back was the use of multiple concurrent anti-psychotics, which you see here. This is exactly in the form in which this committee sent it to DUR. I did indicate, when I sent you all the information last week, the two comments the DUR board did have which, just for consideration of the committee, was that their concern was on the children, the two or more concurrent anti-psychotics. The recommendation was to make that 3 and then also to make the length of the approval for patients under 18, 12 months instead of 6.</p> <p><b>Board Discussion:</b></p> <p>Dr. Adma: This is for children, not the?</p>	<p>Per consensus of the Board: The criteria were amended.</p>

	<p>Dr. Larson: The DUR committee did not have any comments or feedback for the adult criteria only for the children/child criteria.</p> <p>Dr. Moeller: What do you think about; I've been trying; thinking about this a lot. What if we change the age range? For the two or more, would that?</p> <p>Dr. Ellermeier: Lower it?</p> <p>Dr. Moeller: Would there be more acceptance? Like patients less than 13 or I'm just throwing out; got prior approval for two or more. I don't know what other people are thinking, I mean, we all originally voted on this, you know, felt strongly on this, and so I was surprised to see it come back to us.</p> <p>Dr. Larson: I wouldn't be able to speak for the committee members for the DUR. However, if I remember correctly from comments, it was that they felt that 2 or more antipsychotics is common place for children and appropriate prescribing.</p> <p>Dr. Millhuff: Did you say 2 or more?</p> <p>Dr. Larson: Yes. So I don't know if the age limit, I wouldn't be able to say. But there was no, because there was no discussion from the DUR it terms of saying this is not appropriate under 12 but from 12 to 18 it is. It was just more that they felt two or more antipsychotics for under 18 was common/appropriate prescribing.</p> <p>Dr. Moeller: And we, we did a less than 5 needed approval for anti-psychotics or am I? Did we do something like that? Just trying to remember.</p> <p>Dr. Larson: The approved; the other approved criteria is</p> <p>Dr. Smith: I think, just from being in attendance, the hang up was these are also FDA approved as mood stabilizers and 3 or more mood stabilizers is appropriate and in guideline use. So according to guidelines these could be used together as mood stabilizers, not necessarily as antipsychotics, was the discussion.</p> <p>Dr. Moeller: But when they use the word mood stabilizer, yeah at first I want to try to do that, before that, the mood stabilizers, cause there is no evidence that even in adults 2 or more yeah, sorry Liane, did you?</p> <p>Dr. Larson: So this is the other criteria that was approved by this group as well as DUR. It's for age 6 or younger, these particular criteria and association. This is just specifically about using two or more agents.</p> <p>Dr. Moeller: I'm just trying to remember what we.</p>	
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	<p>Dr. Ellermeier: How many; I believe we saw data on this initially.</p> <p>Dr. Larson: Yes.</p> <p>Dr. Ellermeier: How many patients are under 18 using 2 or more?</p> <p>Dr. Larson: So, two or more for the 0 to 18, for 1st quarter 2015 it was 451, this is for greater than 60 days.</p> <p>Dr. Porter: That's pretty big.</p> <p>Dr. Adma: So is there a break down on 13 to 18, and less than?</p> <p>Dr. Larson: I do not have for break down for age, no.</p> <p>Dr. Adma: Karen, I really like your idea of maybe dividing 13-18 and less than.</p> <p>Dr. Porter: You can actually shift the adult criteria to a lower a number, and you do, if you do, you pick a number lower than 18, you pick 13; I would defer to my child psychology colleagues on this one.</p> <p>Dr. Moeller: I would defer to them too.</p> <p>Dr. Porter: That would be the simplest thing to do.</p> <p>Dr. Moeller: What they would think.</p> <p>Dr. Adma: Let me; I think what they're thinking about those 17 and 18 year olds, probably, not the 13 but.</p> <p>Dr. Smith: Based on the discussion, I don't think that will help.</p> <p>Dr. Adma: Is that right?</p> <p>Dr. Smith: Yes. These are mood stabilizers not antipsychotics was the.</p> <p>Dr. Moeller: Was there public comment? We can come to that meeting?</p> <p>Dr. Larson: Yes, there is public comment.</p> <p>Dep. Sec. Dunkel: Yeah, you know we could have, if it's the [inaudible 01:10:28] send it back. We can easily send it back the same way with.</p>	
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	<p>Dr. Ellermeier: Maybe with comment.</p> <p>Dr. Millhuff: I will speak as a child psychiatrist. One of the biggest criticisms I'm getting is that I've got to many, is this, as a group we have too many anti-psychotic medicines going. Whether it's for mood stabilization or psychosis and I am more comfortable with it staying at 2. But that's just my position here. I think as you get closer to 18, yes I can see why they would want it to be 3 but unless we lower the number you know, bring it down like.</p> <p>Dr. Porter: You know what is amazing, if I know my statistics right, okay there was 451 that were 2 or more, not 3?</p> <p>Dr. Larson: 451 for 2 or more.</p> <p>Dr. Porter: 2 or more. And that is one of the highest numbers that we have dealt with any of the categories we have looked at. Like the 3 or more and like the adults is 156 or something.</p> <p>Dr. Larson: 176.</p> <p>Dr. Porter: Ok, so, I'd defiantly defer to you, Chip, but that is a higher number. Indicating its more common than most of the other things we've looked at.</p> <p>Dr. Larson: I think the only thing I could say, I would have to break it down proportionally, is we, in Medicaid have a much larger proportion of children than we do adults.</p> <p>Dr. Porter: Oh, yeah.</p> <p>Dr. Adma: Another thing that the DUR probably does not, and probably have not come across is the new preferred subscriber status that we talking about, right? So once they get to hear what we are talking about maybe they might push it.</p> <p>Dr. Ellermeier: I think the other thing they had took issue with was length of approval, 6 vs. 12, I don't know that. I don't feel strongly either way.</p> <p>Dr. Millhuff: I'm for that.</p> <p>Dr. Moeller: I'm fine with that too. I do, I do have concerns, just you know, change it/allowing, you know again, a 7 year old on 3 anti-psychotics, just to me, I just think that's a concern.</p>	
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	<p>Dr. Millhuff: I will also say, that in the, those practice guidelines from the American Academy of Child and Adolescent Psychiatry that specifically speak to this issue of having two or more anti-psychotic medicines going at the same time, and we all get in that space where you're in a cross over, but to maintain people on more than two anti-psychotics.</p> <p>Dr. Porter: I think the language first. Is it more than two or two or more?</p> <p>Dr. Ellermeier: Yeah.</p> <p>Dr. Porter: Cause it, yeah, it's different, more than two is three or four.</p> <p>Dr. Millhuff: Yeah, right.</p> <p>Dr. Porter: So that we would have to decide which wording we'd want.</p> <p>Dr. Adma: Two or more?</p> <p>Dr. Millhuff: Correct.</p> <p>Dr. Adma: It's not two or more?</p> <p>Dr. Moeller: Correct me, I think a lot of guidelines will say that you know, you can count one of the mood stabilizer but the second one cannot be another, if the first one was anti-psychotic, the other one is not supposed to be, I've seen it in both.</p> <p>Mr. Haulmark: Just for this committee's information, I will say that, the DUR Board, there was one member who was particularly interested in this and swayed his or her colleagues.</p> <p>Dr. Moeller: On the DUR board is there a psychiatrist?</p> <p>Dr. Larson: Yes.</p> <p>Dr. Moeller: Ok.</p> <p>Dr. Adma: I mean, I've been in practice, you know, seeing kids for 16 year. I mean, I get some of the toughest kids and it's not a routine practice for me to have two or more for a long period of time. There is always an exception but it's not common practice, so.</p>	
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	<p>Dr. Millhuff: The other angle at this is the length of time, I've had, doing outpatient work you don't see these kids as frequently and it may take you easily well beyond 60 days to make a cross over, so I can see.</p> <p>Dr. Adma: So we can change that to 120. That would be fine.</p> <p>Dr. Millhuff: That would be better. That would be another way of looking at it.</p> <p>Dr. Ellermeier: So, just increase the time that they can transition? And then, what about lowering the age? Do we think maybe of doing the combination of lowering the age and then extending that time line?</p> <p>Dr. Adma: They need to lower the age until, what?</p> <p>Dr. Moeller: Yeah, what would be a good age? Would like for the 12 and under? And then, do we want adult guidelines for 13 through 18? Or, you know, the first thing would be better than 13, cause this whole thing; they didn't approve the first part did they?</p> <p>Dr. Larson: No. It's all or none.</p> <p>Dr. Klingler: Did they provide reasons or rationales back to us? There's no formal feedback to us?</p> <p>Dr. Larson: Only in terms of, like Jonalan stated, there was a lot of conversation around the mood stabilizers vs. anti-psychotics.</p> <p>Dr. Smith: I was really kind of, having trouble grasping the rationale.</p> <p>Dr. Klingler: That's why I was asking.</p> <p>Dr. Smith: And so I asked if they could provide an example of which two you would use together, you know frequently and no example was given. So that was my concern. Is that correct? So, Seroquel in an 8 year old?</p> <p>Dr. Millhuff: I was thinking, what if you have like a PRN Zydis or something. I could see how you might be using that.</p> <p>Dr. Porter: That's probably it. The kid that has the PRN Seroquel or Zydis and the breakthrough symptoms. That's where they probably get most of this for. I bet those 420 or the 5 whatever.</p> <p>Dr. Adma: My thinking is you can always send it back so that they can kick it back to us again. But, I think if you can change the 60 to 120, which is what they have been asking for, we can agree to that.</p>	
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	<p>Dr. Moeller: No, I think they are asking for 12 months.</p> <p>Dr. Millhuff: But I do like the idea.</p> <p>Dr. Moeller: Maybe 90?</p> <p>Dr. Millhuff: I would vote for more, like, 120.</p> <p>Dr. Adma: I am okay with the 120; I mean I guess they didn't ask for 120, they are okay with 120.</p> <p>Dr. Ellermeier: I don't think they are okay with any of this.</p> <p>Dep. Sec. Dunkel: They rejected it as a whole. I think whatever you guys decide you want to do and send it back is appropriate.</p> <p>Dr. Adma: So, I am thinking, change from 6 months to 12 months. We can certainly increase that to 90 or 120. Whatever the group feels is appropriate.</p> <p>Dr. Porter: I would say 120, maybe.</p> <p>Dr. Moeller: I don't know. I'm deferring to you guys.</p> <p>Dr. Larson: Would that affect just children? Or adults and children?</p> <p>Several Board members respond: This is just children.</p> <p>Dr. Larson: Ok.</p> <p>Dr. Ellermeier: And do we lower the age as well?</p> <p>Dr. Adma: Do we think 16?</p> <p>Dr. Moeller: I've even thought 15 or under?</p> <p>Dr. Adma: Most of the 14 year olds [inaudible 01:17:43]. But when you look at the kids, pre-adolescent, so that's 13. But we are talking 13 on 3 or more anti-psychotics.</p> <p>Dep. Sec. Dunkel: Negotiate back to a center point.</p>	
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	<p>Dr. Millhuff: I am thinking of when to do adolescents start to show signs or symptoms of schizophrenia and to have it younger than 11, it would be very unusual. You get up closer to 14 and 15 and I think you are starting to see more occurrences of a primary psychotic break and you've got mood instability and all kinds of; it just becomes much more complicated. So I would say maybe 14. I just, that's not a very, I don't feel like I have enough evidence to say that number off the top of my head.</p> <p>Dr. Moeller: Greater than or equal to 14? 15?</p> <p>Dr. Millhuff: Right.</p> <p>Dr. Moeller: So we would change the adults to?</p> <p>Dr. Ellermeier: 15 or over.</p> <p>Porter: I forgot my tanner stages by 15 most everybody is in, was it 3, I forget the rates?</p> <p>Dr. Moeller: 3.</p> <p>Dr. Klingler: 4.</p> <p>Dr. Porter: Yeah, they're mostly getting closer to adult physiology by that time.</p> <p>Dep. Sec. Dunkel: So then, greater than or equal to 15, and then under 15?</p> <p>Dr. Millhuff: Right.</p> <p>Dr. Moeller: Let's see what they do.</p> <p>Dr. Ellermeier: Should we also, perhaps, submit some comment to them, as well? Maybe we can type something up to send?</p> <p>Dr. Adma: Yeah.</p> <p>Dr. Larson: You can always attach, just as I, it's exactly the same process, just as I send everything to you a week in advance, I also send to them in a week in advance. So I can include information at that point in time, or we do have, as here, public comment that is available. Or can present public comment if not, no one is available at the actual meeting.</p>	
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	<p>Dr. Porter: Can we say as a group, that collectively they don't know what they are talking about in regards to the mood stabilizers?</p> <p>Dr. Larson: I will defer to you on that one.</p> <p>Dr. Adma: Here's my concern. If it is just one member of the team who is swaying the whole team, I mean, I don't know if that is accurate, then that's going to be a problem and if you were to compromise, and then this change it to. My theory is there's a lot of studies which says pre-adolescent adult, that's the cut off. There's nothing that says 15 as a cut off, that at least I know of. So we're just arbitrarily picking a number. I would probably be more comfortable with us saying, you know, we're going to change the length of approval to 12 months. We're wanting to change the duration for 120 days, send it back to DUR, and then maybe public comment. It can come back, that's okay, but I think that's a safer thing for us to recommend, rather than just compromise, you know?</p> <p>Dep. Sec. Dunkel: So for the action of the committee then, what we'll throw out there for a quick yeah or nay; is the recommendation is to send back to DUR the criteria as was provided here with two changes. One, patients under 18, two or more anti-psychotics used concurrently for greater than 120 days instead of 60 days and the length of approval moving from 6 months to 12 months.</p> <p>Dr. Larson: Can I?</p> <p>Dr. Porter: Go ahead.</p> <p>Dr. Larson: I just have a question, just so I am able to answer for when the DUR board has a question about it; just because I'm unfamiliar with it; is, why would you do 120 days in children and not in adults?</p> <p>Dr. Millhuff: What is it for adults?</p> <p>Dr. Larson: Its 60 days. Its 60 days to allow for them to be on concurrent for 60, in adults but 120 for children.</p> <p>Dr. Moeller: But they're 3 or more.</p> <p>Dr. Larson: Correct.</p> <p>Dr. Moeller: So.</p> <p>Dr. Larson: I just want to have an answer for.</p>	
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	<p>Dr. Moeller: Really, again, even 2 or more is.</p> <p>Dr. Adma: More gradual titration or tapering of the medication in children compared to adults?</p> <p>Dr. Larson: Is it more appropriate in children than adults?</p> <p>Dr. Millhuff: I can just say working with kids, the slower, starting low, going slow and coming down slowly and carefully.</p> <p>Dr. Larson: Ok. Just that way I can answer that question if it comes up instead of.</p> <p>Dr. Adma: We do have a lot of kids on KanCare, in foster care population who do have multiple mood swings sometimes it takes a lot longer.</p> <p>Dr. Porter: It maybe not 120 but I am just thinking of the scenario were again somebody comes out of the hospital as an adult and the time frame it takes them to get into an appointment. Some of the mental health centers around here are weeks and weeks to get in for your first appointment. It might be good to make that 90 to give a chance to taper, gather information, given the delay in appointments that I hear about.</p> <p>Dr. Ellermeier: What were the numbers for adults again?</p> <p>Dr. Larson: The adults were 176 on 3 or more for 60 days.</p> <p>Dr. Adma: Did you look at 90 day mark?</p> <p>Dr. Smith: No.</p> <p>Dr. Porter: I guess as we just extend one and look at the other one, well, it would probably be good, give it a little bit more time, given.</p> <p>Dr. Millhuff: And you're also dealing with other factors in terms of the, who the child is dependent upon, the environmental factors, engagement, and other services. I also throw in this idea of if you are using the PRN, maybe your still kind of stabilizing that person, gives you a little bit more time to kind of get things settled out and can use that second anti-psychotic, like Zydys, if that were the case. Those are some ideas.</p> <p>Dr. Larson: Thank you.</p> <p>Dr. Ellermeier: So are we saying to go ahead and change the adults to 90 days?</p>	
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	<p>Dr. Porter: I would suggest it, but I am not the only one on the committee.</p> <p>Dr. Moeller: Maybe the adult, yeah. I mean, if we wanted to be consistent, we would have them both the same. I would be more favorable for them to be 90, but if we're ok with having different than.</p> <p>Dr. Adma: My theory is the DUR has already looked at this and their okay with it and now changing it, and sending it back, that's my theory. I'm okay with it.</p> <p>Dr. Moeller: Let's just try the 120 and?</p> <p>Dr. Adma: See what they say.</p> <p>Dr. Porter: On the both of them?</p> <p>Several Board members at once: "No", "Only on the kids", "Just on kids"</p> <p>Dr. Porter: Alright.</p> <p>Dr. Moeller: It's too restrictive, it's 2 or less; it's for 2. The adults are 3 or more.</p> <p>Dr. Ellermeier: Yeah, and were also not saying, that they cannot get two or more or three or more, were just saying there needs to be a reason.</p> <p>Dep. Sec. Dunkel: Is there anyone who would be against that being what we send back to the DUR? From a consensus as opposed to a vote this time?</p> <p>[Silence]</p> <p>Dep. Sec. Dunkel: Alright. That is what we will send back to DUR then for the committee.</p> <p>Dr. Porter: Can I make one more comment about that? I think, Chip alluded to it, I think there's a, also kind of a PR thing about kids and psychotics right now that, if we're not really sure about something I think not okaying more is probably a good move in that direction.</p> <p>Dep. Sec. Dunkel: Yeah, and I know from and you guys know too, from all the drive on the CMS, and even the push on some of the HEDIS factors, HEDIS measures is going more towards what you guys left in here for the kids, so.</p>	
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<p>II. Old Business</p> <p>B. Prior Authorization Criteria</p> <p>2. Use of Benzodiazepines and Buprenorphine Products – Review proposed clinical criteria for medication assisted treatment program patients prescribed benzodiazepines.</p>	<p><b>Clinical Public Comment:</b> - No requests were received.</p> <p>Dep. Sec. Dunkel: Next thing, Liane.</p> <p>Dr. Larson: Okay, the next criteria we had that was presented at the last meeting and this was on the Buprenorphine and Benzodiazepine, portion of this criteria. So as last time that in black is the currently in place criteria and this discussion is surrounding the addition of these criteria here in which patients must not be prescribe Benzodiazepine concurrently with the Buprenorphine. And so, this was tabled last time and brought back this time for discussion.</p> <p><b>Board Discussion:</b></p> <p>Dep. Sec. Dunkel: Thoughts from the committee?</p> <p>Dr. Ellermeier: This falls under the committee because we would be denying Benzo claims?</p> <p>Dr. Larson: Correct, correct. So, previously this was approved by DUR but the addition it felt bringing to this group because of the addition of a criteria surrounding a Benzo. We want it to go through here prior to going to DUR.</p> <p>Dr. Adma: I am not certified in the Suboxone®. Is anybody on the committee?</p> <p>Dr. Porter: No, we talked about it.</p> <p>Dr. Moeller: I think that's why we're all uncomfortable.</p> <p>Dr. Ellermeier: What if instead of um the Benzo claims denying, that the Suboxone® claim denies if their filling a Benzo? Does that create problems, administratively to actually administer that?</p> <p>Dr. Larson: I don't think it creates problems, necessarily, administratively, because one or the other can be denied. The concern, why it was presented this way was, that it felt in internal discussions that having the Buprenorphine, was more important than the Benzo, and that the Benzo was added on. So not wanting to deny somebody if they are using it for Opioid addiction, not wanting to deny that verses in terms denying the benzodiazepine. And for, and it's just again, you know, as we said a concern is because of respiratory depression with that. And when we did do the numbers we had 24% of our patients that use Buprenorphine who use Benzo scripts.</p> <p>Dr. Adma: Twenty?</p>	<p>The criteria were Tabled.</p>
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	<p>Dr. Larson: 24%.</p> <p>Dr. Adma: Big number.</p> <p>Dr. Larson: It was, for the first quarter of 2015, it was 55 out of 229.</p> <p>Dr. Moeller: Because that could, I think a lot of us are just having a hard time, because we don't work in Suboxone<sup>®</sup> clinics to make the recommendations. I defiantly agree, I mean, I think this is a good thing is 30 day, that's 24% that is a large number and so, abruptly stopping a Benzo that fast, I feel, I mean, I think it's good and I but.</p> <p>Dr. Porter: And the background we got on this, there have been deaths, a fair number of them, related to the combination of them, is that what we heard last time?</p> <p>Dr. Larson: Yes, it's kind of, a lot of other states Medicaid programs have enacted the criteria surrounding this due to the fact to across the nation they are seeing an increase in deaths associated using both of these drugs.</p> <p>Dr. Ellermeier: The other, I think, the Benzos are typically inexpensive, as we're talking about generics so, if both weren't paid there's nothing to stop them from still getting there Benzo.</p> <p>Dr. Larson: That is correct, this is just to stop Medicaid paying if the individual wanted to then pay cash for it, then they would be allowed to.</p> <p>Dr. Ellermeier: Would there be outreach to the members that are currently taking both prior to implementing this?</p> <p>Dr. Larson: That is something, as with the others, we would be able to do. I'm sure the MCO's would be able to, just as we to identify those individuals, identify those as well and be able to do lettering ahead of time.</p> <p>Dr. Shoyinka: So I am board certified in addiction medicine. And I have run a Suboxone<sup>®</sup> clinic before, um and I am in support of these criteria. It's simple safety mechanism.</p> <p>Dr. Ellermeier: I don't know if any of us know what to say.</p> <p>Dr. Adma: Are there any contra indications for people on Suboxone<sup>®</sup>? I have not worked with Suboxone<sup>®</sup> patients, so should they not be prescribed Benzos at all? Or is it just because of could have been issues or substance abuse issues that you're just saying no Benzos?</p>	
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	<p>Dr. Shoyinka: It's both, it is both a safety issue, really, it's less on the Buprenorphine side, that does have a effect but, it's not just, it's not just Benzodiazepines it's these you know, non-benzodiazepines sleep agents. It's the antihistamines. Its alcohol. It's every sedative; the general problem is you don't want to have both in the same person. And, and, as we know addictive patients, you know, do tend to reach for reinforcing agents, other than enforcing agents.</p> <p>Dr. Adma: Ok. Is this something that again, I have not worked in a Suboxone® clinic before so, is this something we need to maybe ask somebody?</p> <p>Dr. Porter: I think we have, what we have I guess, we can take on faith that this is similar to initiatives, are common in other states without you know, let's take that on faith as well, we have on board a certified board Addictionologist amongst us today that says it's a good idea and I, one thing might be to just accept that. I'll just put that out there.</p> <p>Dr. Ellermeier: I think, as long as there's the caveat that there would be an outreach ahead of time and some members would be educated ahead of time potentially even prescribers there could be an issue where this is two doctors prescribe, two different doctors, not the same clinic and so it could be a potential good education piece for subscribers as well.</p> <p>Dr. Larson: When I did run the data it was about 50/50. 50% from the same prescriber and 50% from two different prescribers.</p> <p>Dr. Klingler: Would it be possible to maybe get a review article or something that gave us some evidence based criteria for making this decision?</p> <p>Dr. Larson: Sure.</p> <p>Dr. Klingler: I think what I am hearing is none of us use this drug or are familiar with it and I guess I would like to have, except for you of course; but I would like to I guess practice evidence based medicine with what we're doing here as much as we would in our own practices and just make ourselves a bit more informed about this before we made a decision. Others may not feel that way, but I think would be good stewards of what we're doing, I think that would be appropriate.</p> <p>Dr. Shoyinka: I just reviewed the literature around this and I would be happy to share that. It's not just around Benzos and Opioids. It's pretty broad, broadly across other substances as well. If that would help.</p> <p>Dr. Klingler: I think that would be very helpful if you have a literature review.</p> <p>Dep. Sec. Dunkel: If you can provide that to Liane?</p>	
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	<p>Dr. Shoyinka: Sure.</p> <p>Dep. Sec. Dunkel: And then we can distribute it to the group and that way we have it too.</p> <p>Dr. Porter: I think the thing that came up last time that got all our attention in our brief interaction with it, was the Benzos are uniquely, compared to some of the other agents you mentioned are respiratory depressants and then that would be potentially more dangerous combination than even some of the other others chemical somebody might take; am I remembering that right?</p> <p>Dr. Shoyinka: Yes, correct.</p> <p>Dr. Porter: Ok.</p> <p>Dep. Sec. Dunkel: Great. So with that, would everyone be comfortable with tabling that until we have the information that Sunflower is going to provide and we'll talk around a little bit too and see if we can't find someone not related to this process. Maybe come in and talk about it from Kansas City or Topeka or somewhere else? We'll see if we can't get someone.</p> <p>[No opposition to tabling the criteria]</p> <p>Dr. Ellermeier: Or even comment, if someone is not able to come in and maybe get some information, might be great.</p>	
<p>III. New Business</p> <p>A. Prior Authorization Criteria</p> <p>1. Stimulants and other ADD/ADHD Agents Dosing Limits – Review proposed daily dose limits for patients prescribed stimulants and other ADD/ADHD agents.</p>	<p><b>Clinical Public Comment:</b> - No requests were received.</p> <p>Dep. Sec. Dunkel: With that we'll move on to New Business. The first one up is Prior Authorization Criteria for Stimulants and other ADD/ADHD Agents Dosing Limits.</p> <p>Dr. Larson: So as we have done before with other classes, were just moving now on to stimulants and other ADD/ADHD medications. These are the proposed limits just set out to be a starting point to work from in terms of for these medications listed.</p> <p><b>Board Discussion:</b></p> <p>Dep. Sec. Dunkel: Comments from the Committee?</p> <p>Dr. Millhuff: Just one basic comment about ADD/ADHD. I'm curious why we put ADD when that's not really the nomenclature?</p>	<p>The criteria were tabled.</p>

	<p>Dr. Larson: That'd be fine. I can change that. I was, in my review of other states criteria, that's the wording that was used. But I can defiantly change that.</p> <p>Dr. Porter: As long as you don't go back, Chip. If you go back, I have been spending like the last 20 years telling people the difference. Keep it the same for awhile.</p> <p>Dr. Adma: My only comment to this is, with obviously we're doing it as a blanket. It does not differentiate between 5 year old, 6 year old, versus a 25 year old. It is blanket, right?</p> <p>Dr. Larson: Yes.</p> <p>Dr. Adma: For kids and adults?</p> <p>Dr. Larson: Correct.</p> <p>Dr. Ellermeier: Yes. So this would be the max anyone could get. I think Liane had asked for input on others, where we would want some cut offs for future meetings.</p> <p>Dr. Klinger: And we don't use weight based dosing in this class of drugs for pediatrics. It's the only exception really, that I can think of, that it's titrated to a fact rather than instead of weight based dosing. I can have a 200 pound kid on ½ a dose of a 70 pound child. So it's titrated to a fact. In looking at these as far as primary care goes, I think these limits are reasonable for what we do in primary care.</p> <p>Dr. Porter: Maybe, sometimes we're given numbers like, how common something is. Is that something we have for this?</p> <p>Dr. Larson: So, overall, for every, for all this. This is children, adults, and everything - 1,523 would hit the edit.</p> <p>Dr. Porter: In a quarter?</p> <p>Dr. Larson: Yes, in a quarter. The majority of those, I can just give you a couple that were the highest outliers, was the Vyvanse and the Intuniv.</p> <p>Dr. Adma: Intuniv is 7. So was it more than 7?</p> <p>Dr. Larson: Yes.</p>	
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	<p>Dr. Millhuff: Is there any other reasons why Intuniv was picked up? Is this strictly on dosing amount?</p> <p>Dr. Larson: This is on the claim. What they actually had filled during a month. Well, their day's supply; take how much they received by their day's supply. That's how it was calculated.</p> <p>Dr. Millhuff: Because, the issue with Intuniv is that a lot of us are using it twice a day. And the, I think, the dose optimization has it just as one pill a day.</p> <p>Dr. Smith: On the low dose.</p> <p>Dr. Klingler: 1 and 2 mg?</p> <p>Dr. Smith: Right. The 3 and 4mg</p> <p>Dr. Millhuff: Up to twice a day?</p> <p>Dr. Smith: It's open completely unless you vote on this policy.</p> <p>Dr. Millhuff: Oh.</p> <p>Dr. Smith: So you could get 3 – 3s right now. Right, Liane?</p> <p>Dr. Larson: Yes. So, the dose optimization, like Jonalan was saying, so if there's a 1mg, a 2mg, and a 4mg, it would only dose optimize those in which you don't double up and that there is a dose available. So that's why, for instance, you are only allowed to receive one - 1mg per day because there is a 2 mg available and one 2mg because there is a 4mg available. However, with dose optimization, it does not put limits if there is not a doubled dose available. So on 4mg, you could prescribe 10 of them currently.</p> <p>Dr. Millhuff: We could do a 2mg, twice a day?</p> <p>Dr. Larson: You would not be able to do two 2mg twice a day because of the 4mg dose optimization.</p> <p>Dr. Millhuff: So, I'm curious how many of those have come up on your radar screen because of dosing it BID.</p> <p>Dr. Larson: That would not hit our edit. Two 2mg dosing, because that wouldn't be more than 7mg in a day.</p> <p>Dr. Millhuff: So, it's only anything above 7mg?</p>	
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	<p>Dr. Porter: Two 4mg would.</p> <p>Dr. Larson: Yes, 2 4mg would.</p> <p>Dr. Moeller: This is the adults getting it? I don't know how many adults get Intuniv.</p> <p>Dr. Larson: Yes.</p> <p>Dr. Millhuff: And that 7mg is newer to the approval dosing limit from what I know. When I saw the list, I didn't know it went to 7.</p> <p>Dr. Adma: The max I've seen is 4.</p> <p>Dr. Millhuff: It's in the prescribing information.</p> <p>Dr. Ellermeier: Up to 7 in the prescribing.</p> <p>Dr. Larson: This is my initial, when I first started looking at everything, just to give you some idea of the other states.</p> <p>Dr. Millhuff: So it's pretty much 4mg across the board.</p> <p>Dr. Larson: We could defiantly have it at the 4mg.</p> <p>Dr. Porter: We already have 1,523, that's a lot of prior auths. It makes me wonder before we move forward. That's a lot of phone calling. I don't know what you guys are going to do with the process, I won't be around for that. But if it's going to involve a phone call, every time there's a phone call, that's one patient that's not being seen during that slot. I think we really have to look at something about these criteria with that many outliers.</p> <p>Dr. Klingler: Liane, is there one or two drugs that hit that edit more than other ones?</p> <p>Dr. Larson: Yes, so Vyvanse hit it 411 times and Intuniv hit it 220 times. Methylphenidate across, I don't have it broken down by each individual type of drug, but across the board, Methylphenidate 442 times, that's for all the different versions. Those are the highest I would say.</p> <p>Dep. Sec. Dunkel: So basically 2/3 of the 1500 come into those 3 categories.</p> <p>Dr. Adma: Was it mostly for the adults or for the kids?</p>	
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	<p>Dr. Larson: I don't have any breakdown for age.</p> <p>Dr. Moeller: I would hope we would see the maximum being exceeded more in the adult population.</p> <p>Dr. Adma: There's still some people are prescribing based on weights too. Some prescribe a lot higher too because of that.</p> <p>Dr. Porter: I'm not a Neurologist. This is just an impression, I'll get educated on this. For actual Narcolepsy, we'll use doses higher than what would be prescribed for ADHD, and I don't know how much of this is explained by that.</p> <p>Dr. Larson: I included the doses if they were for Narcolepsy as well.</p> <p>Dr. Moeller: [01:42:20 inaudible] the students telling me while I was teaching in class that they are seeing Adderall. I was surprised that Adderall didn't hit. They were seeing up to 80 a lot.</p> <p>Dr. Larson: Adderall had 137.</p> <p>Dr. Porter: We don't have a Neurologist on the committee. I think that's probably an important factor to know how much of this is for sleep disorders from Neurology versus ADHD.</p> <p>Dr. Adam: So, Liane, one of the things that we've done is, we have taken one step above the FDA approved doses for some of these medications, right? So, for the stimulants, we are essentially limiting to; are these the FDA approved limits, for the most part?</p> <p>Dr. Larson: Some of it goes above that.</p> <p>Dr. Porter: XR says 30 but we allow 60.</p> <p>Dr. Larson: So this column here is, out of what I could find, like FDA package insert or through facts and comparisons. So as you'll see here, yes, like you were saying, Adderall 30mg, we're allowing for 60. Some of them do coincide and some of them do not. Just based on what I could find out there, other approved criteria as well.</p> <p>Dr. Porter: I think what has come in handy with the limits at the PDR recommendation in my practice is, you have a fair number of folks that really, really like this kind of medicine. And I think if you have a clinic that you just say we don't go above the PDR, I think it sort of short cuts the discussion, that can take up a lot of your energy. I guess that's just my clinic and my practice. I really try to avoid doses higher than the PDR.</p>	
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	<p>This is a lot of PAs, if we don't figure out something about these criteria. These guys are going to be working just has hard putting them out as we will be answering them.</p> <p>Dr. Moeller: And if necessary, could they do a Methylphenidate, you know, start at 72mg but then also do an immediate release on top of it?</p> <p>Dr. Millhuff: You can use both.</p> <p>De. Larson: Yes.</p> <p>Dr. Ellermeier: You could use one of each of these, right?</p> <p>Dr. Larson: Yes, we don't have any dose criteria at this point in time.</p> <p>Dr. Millhuff: I think that for Primary Care, these numbers make sense to me.</p> <p>Dr. Klingler: I think. Very much so.</p> <p>Dr. Smith: For limits, you mean?</p> <p>Dr. Millhuff: Yeah, for my practice, I've got, you know, going up to 108 on Concerta, going beyond, maybe, 100. You know, we're going to go higher with these kids. The other thing that we run into as well is, not just QD dosing on some of these meds. We're using, you know, like for instance, the kid that takes 72 of Concerta in the morning and then another 36 at Noon and what if they're rapidly metabolizing this or. It's another angle to this in terms of the amount of capsules or tablets we can use in a day.</p> <p>Dep. Sec. Dunkel: Let me ask this, then. When we had the conversation earlier about starting to tier out; so if we went through and said ok, for table 1, maybe create a set in another column, first column being; I don't know how we want to describe it.</p> <p>Dr. Klingler: Could we use the same verbiage that we have used on the antipsychotics? Instead of 'two or more' saying 'doses above this must be prescribed by or in consultation with Psych, Neurology, and Developmental Behavioral Peds'?</p> <p>Dep. Sec. Dunkel: So column 1 that'll be for everybody else and then we can create a column 2 that's for the folks that are on that list.</p> <p>Dr. Klingler: I think that same verbiage would be consistent.</p>	
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	<p>Dep. Sec. Dunkel: Do you want it just have it be a straight multiplier? I mean is it, here's the list of everybody that not currently in this other list. For these folks it's basically the insert and for everybody else it's 150% of the insert. Well, for everybody else, the 3 provider; 2 provider classes that are in there. It's kind of what we did on the other one. And that's why I'm throwing it out there. I mean, I'm not clinical nor do I pretend to be, but, you know, the other dosing lot we had, basically took, for the most part, took 150% of the insert.</p> <p>Dr. Larson: We've done different. We've manipulated different ones, different ways. We did with the Abilify a couple times just to get it where the committee wanted.</p> <p>Dep. Sec. Dunkel: Does that make sense and respond to your concern?</p> <p>Dr. Millhuff: Yeah, I'm looking here at this guidelines for what Texas uses. They have what they call Literature Based Maximum Dosage. They have these headers like Concerta, which is probably the number one prescribed medicine. It's 108mg per day. I think that there's a handful of them that are represented as used more commonly used medicines. They've been around longer. So you can see the higher dosing amounts. So if we could make, you know, provision for having the higher end, like you're saying, I think it would make sense with some of these. The other thing about this discussion, I just want to say is, I wasn't here for the antipsychotic discussion, but, a major concern of mine, particularly when we get to the younger children, is the starter dose. We're not really taking that on here. That's a big mistake. I think with some of these kids they get started to high. It's harmful with some of these medicines. I'm just putting that out on the table. Do we ever want to add that as part of the parameters that we're setting here? Where to start depending upon if you're a preschooler with these meds. It's delineated here in this Texas algorithm here. And I think it should be done.</p> <p>Dr. Moeller: I think one of the things we're talking about too is just getting maybe first a general dosing guidelines as of now. You know, a five year old could get 108mg of Concerta.</p> <p>Dr. Millhuff: That's what worries me.</p> <p>Dr. Moeller: And so, having this at least on board and then going, cause I think Liane had asked if we had dosage recommendations, I think that that's something we maybe need to talk about under New Business or just what, cause I don't think it's hard for us to give Liane guidance when we're not sure if we want dosing ranges from 13 to 18 or if it you know you know 5 to 10, you know, it's hard for us to give guidance and she can't do that without us, if we don't even know. Does that make sense?</p> <p>Dr. Ellermeier: Yeah, I agree. Perhaps, I mean, maybe we should address what we have in front of us today. But I also think it would be helpful if we outline the other things that we would like to look at for her and the breakdown of ages, so that, you know, we can have a meaningful discussion with something in front of us.</p>	
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	<p>So, Perhaps, maybe it's our task, out of this meeting to kind of all go home and throw together some ideas of what are the broad, just the broad picture of everything that you want to look at in general. Get that outlined and then start getting into the weeds of what are the particular doses under each of those categories for particular limits.</p> <p>Dr. Porter: So what the committee wants to know, I have a colleague, and he agreed with not allowing paying for Benzos.</p> <p>Dr. Adma: Thank you for doing that. I think that if that is the recommendation. Based on what Liane put together, most of these doses are very similar to what other states are already approved at, right? It's not anything different. Only difference I see is Intuniv. Which is 4mg in those other states and we're at 7. And you're saying even at 7 who have what 25% or something.</p> <p>Dr. Larson: So it's 220. 14%.</p> <p>Dr. Adma: 14% which are prescribed more than 7mg. Which is interesting.</p> <p>Dr. Ellermeier: As monotherapy the limit is 7. As adjunct is 4. I would guess that a lot of the adjunct that are over the limit, it's quite a bit outside of what it should be.</p> <p>Dr. Adma: Because we are also talking about the preferred prescriber status. There will be exceptions. Looking at what other states are doing, is it reasonable for us to use this as a starting point?</p> <p>Dr. Millhuff: I think it is.</p> <p>Dr. Adma: I think most of the medications, I've never prescribed anything more than what is listed. Exceptions are there, but not common.</p> <p>Dep. Sec. Dunkel: We've been going through and agreeing to come back. Again, what we talked about last time, additional conversations around children dosing, starting dose limits, what kind of table we want to create off of these really base limits. These obviously were, even the ones we talked about last time, were kind of first visions of maximums we want to put in place. So that's just a matter of whether the committee is comfortable with moving forward and recommending this for inclusion with the next DUR pack or do we want to hold off and wait.</p> <p>Dr. Ellermeier: Our new process, though, is going to be, since it's a new criteria, it would come back next time with whatever changes we may decide. As a formal? Ok.</p> <p>Dr. Millhuff: May I raise just one good point too?</p>	
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	<p>Dep. Sec. Dunkel: Yes.</p> <p>Dr. Millhuff: Maybe this has been covered. I'm just looking at this dose optimization chart here. And we were talking about Intuniv. Intuniv has a titration schedule that has you raising the dose by 1mg tablet every week. And so, I'm thinking about a lot of the people that I serve who have limitations in transportation. Whether that means coming to see me or getting to the pharmacy, and so commonly what I've done is I've sent them out with a titration schedule. So that they would increase their 1mg tablet up to two 1mg tablets on weekly increments as it's in the prescribing information. Does the dose optimization/consolidation plan, limit me from using more than one Intuniv tablet a day?</p> <p>Dr. Larson: No. The dosing optimization is just for the; not allowing for sixty 1mg tablets in a 30 day period. Instead allowing for the 2mg tablets. I don't remember each dose for each medication. You can use two different strengths.</p> <p>Dr. Millhuff: Right. So, would I, how would I, would I write two separate prescriptions for that then?</p> <p>Dr. Larson: You could write two separate prescriptions, or I would go back to the MCOs in the sense that, if it was indicated that you were doing a titration, would that be an override for the dose optimization.</p> <p>Dr. Millhuff: Jennifer and I had this discussion on the phone a while back and it was around a stimulant. At the beginning phase. And I see a lot of young children, so I'm starting low and I'm titrating carefully and so I'm usually giving them an opportunity. I'm not just trying to start right out of the chute with the dose I think they're going to be at. I've started low and creeping up on it. If I've got to give them, ok here's a prescription for 7 days at this dose, and here's another prescription for this dose, and then here's another one. It makes it much more complicated in terms of having different dosing strengths. And so I'm just raising this as an issue in terms of careful titration, maybe this is something we'll get back to when we get to talking to younger kids. I find that there's some limitations with the quantity of tablets or the way that, because what I've seen is, the prescription itself has been, it doesn't go through, it goes to peer-to-peer review.</p> <p>Dr. Larson: And that's why there'd be those two options in terms of if you didn't want to do the individual prescriptions and you did want to do it that would be it would be under the current system that there would be an override. That it would allow, in terms of allowing for the 1mg tablets to be used. So there's the two different options that you could go with that route.</p> <p>Dr. Ellermeier: So the default would be point-of-sale, it would decline.</p>	
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	<p>Dr. Larson: It would decline at point of sale, because it's, if it's looking at 60 tablets in a 30 day period, the system is saying, why can't you use 30 of the above strength, but that is able to be overwritten under these cases of titration or can be using different prescriptions for different strengths to titrate up.</p> <p>Dr. Millhuff: Well, what I'm getting at then is, can we have some kind of exception built into the system to where we don't have to have a review if it's obvious that we're in a dose seeking phase. We're initiating the medicine. We're trying to get there.</p> <p>Dr. Larson: I don't know if the systems are smart enough to know that it's a titration.</p> <p>Dr. Millhuff: That it's a new start.</p> <p>Dr. Larson: No. I wouldn't be able to</p> <p>Dr. Smith: We could have a 15 day window where there's no limit for 15 days. But I don't know if that's long enough for your titration.</p> <p>Dr. Millhuff: It would be close. I would be better than not having it at all.</p> <p>Dr. Smith: So 15 days, so the pharmacy, instead of giving them 60 tablets, they could bill for 30 with a 15 day supply and then refill it at 15 days, but then the dose optimization kicks in. I don't know if that's enough.</p> <p>Dr. Millhuff: Here's the problem, let's say I start a child on 1mg. We give it 7 days. We go to 2mg and we're getting a partial response, we give it another 7 days; we get to 3mg of Intuniv and suddenly that's too much and then they don't have any of the 2s leftover to fall back on. So you have to get a little bit more creative I think in the; or just simply slow, way slow down your titration schedule where you're just making incremental changes every time they come in or longer periods of time. I find that this dose optimization thing has affected the practice. You lose sort of the flexibility in your dosing amounts.</p> <p>Ms. Cobb: What flexibility is there in the system to change the dose optimization? If someone feels like they can't safely prescribe the medication, then that's a problem.</p> <p>Dr. Smith: It might be something we can look at with the gold card. Because I don't know that there's a lot of prescribers that practice at the level that Chip is able to do just because he sees so many patients. I don't know. Maybe I'm wrong. You'd have a better perspective.</p> <p>Dr. Millhuff: I have to say I'm coming from the angel of a guy that works with a lot of preschooler kids and so I'm starting low and going very carefully. And just making little changes but not trying to take too long to get there. So maybe I'm really unique.</p>	
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	<p>Dr. Smith: I have no concerns over what with Dr. Millhuff is saying.</p> <p>Dr. Klingler: Using Amoxicillin 200 per 5 or 400 per 5, you know, it doesn't matter. But with something like this it does. Can that class of drug be broken out so that the stop isn't there at the point of sale? I mean, Amoxicillin, not a big deal if they. Two teaspoons of 200 or.</p> <p>Dr. Larson: I'm not able to determine. It is written, it is across the board in terms of doing the dose optimization just because of what we did see previously. In terms of people on two a day drug, maybe even more, for long periods of time. It was costing the State a lot of money. And also wanting to reduce co-burden for individuals. That was more the motive behind it. And since a lot of times people weren't titrated, and then the titrations never got converted to a higher dosing on the tablet. And people were just stayed. And they weren't taking things, we could see, not twice a day, they were instructed to take 2 of them once a day and continuing on. So that's when dose optimization came in. But, as I sent you the information before, it's not something that; it was specifically initiated last year in legislature for us to be able to do. So it came in. That's why, looking at those types of situations, that's why we give the two different options in terms of writing the different prescriptions, I hate to keep going back to that, or allowing for the override for those exceptions when you do have it where you're doing these low titrations. To allow to say I'm doing this and to have the override put in and then it's not an issue. But I don't know in terms of system wide if you, being able to put something to say for these particular drugs.</p> <p>Dr. Smith: That was one of the things that were carved out, left to the MCOs. But I would say, kind of like what Nicole was mentioning earlier, now that we've got 6 to 9 months of data, we'd be interested in having discussions. Now that prescribers are kind of used to this, what are the lingering issues that maybe we can help you address? We know now. The shock to the system is over. So I'm happy to follow up with you too. Just say, you know, which ones of these specific ones, are you encountering frequently?</p> <p>Dr. Millhuff: The other thing is with Kapvay you have that kind of precedence set and it's the QD or BID and it's the same drug category. And, so, I think what a lot of us have found, is that what BID does for Intuniv, we get better polymer and sometimes better efficacy that way. I know that some colleagues have just; this stuff really effects the way people prescribe. Some people go ahead and just start breaking them in half, which is not a proper way to use this, perhaps so that they could stay with that BID dosing. And they're still writing it, now they're writing it the way you want them to write it so they don't have to do the review.</p> <p>Dr. Porter: I was just going to say, if this is allowed, I just wanted to make a couple quick comments on the last one.</p> <p>Dep. Sec. Dunkel: Obviously we are a few minutes over our scheduled meeting. I'm ok with extending it out to 4:30pm if everybody is available and can do that. I can't force you to stay.</p>	
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	<p>Dr. Porter: If that's the case, I'll stop interrupting Chip.</p> <p>Dr. Adma: For my clarification; extended release plus immediate release; if somebody's prescribed Concerta and say a short acting, would that be approved?</p> <p>Dr. Larson: Yes.</p> <p>Dr. Adma: Ok.</p> <p>Dr. Larson: It's only specific on the agent within that particular medication.</p> <p>Dr. Millhuff: The other thing is you don't have short acting alpha agonists listed here.</p> <p>Dr. Larson: No, we can include what you want. Like I said, this is literally just a starting point from what I could gather from other states or other clinical reviews. But I can include or remove anything that the committee feels necessary.</p> <p>Dr. Millhuff: I would suggest you add Tenex and Guanfacine and Clonidine. And make the dosing limits...</p> <p>Dr. Ellermeier: So basically the IR formulations.</p> <p>Dr. Millhuff: IR forms and a .4 for the Clonidine, I would suggest be the limit. And 4mg for the Tenex.</p> <p>Dr. Moeller: I don't know, I'd have to go back and look. Cause, are the hypertension they're much different so this would if you'd put Guanfacine or Clonidine down it's going to trigger anyone using it for hypertension. So we need to make sure, I don't know what the.</p> <p>Dr. Adma: What is the dose for hypertension?</p> <p>Dr. Porter: It's not lower hopefully.</p> <p>Dr. Moeller: But Guanfacine is not use much anymore but I'm sure there is a doctor out there...</p> <p>Dr. Ellermeier: Guanfacine, Tenex, it doesn't have a specific limit for hypertension in adults but it does say adverse reactions increase significantly with doses above 3mg per day.</p> <p>Ms. Cobb: It's usually 0.1 or a 0.2. Very seldom do you see a 0.3 for hypertension.</p>	
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	<p>Dr. Ellermeier: So I think, It seems like maybe we would be safe, but perhaps there should be a data pulled.</p> <p>Dr. Moeller: I'm just saying, for the two it's used.</p> <p>Dr. Millhuff: Also, I too, on the short acting it's clearly recommended in the practice guidelines for young kids as a start for some of these conditions.</p> <p>Dr. Larson: And I think why we didn't include it initially was because of the other label indications but definitely can add them. I don't think the system would be able to stop the prescription from not going through for those not using it for those indications as well.</p> <p>Dr. Adma: So if it's indicated for hypertension, would that go through at a higher dose?</p> <p>Dr. Larson: No.</p> <p>Dr. Smith: We could put it in the criteria as a removable criteria.</p> <p>Dr. Larson: It would still hit the PA. Because then, if the patient, even if we had if for diagnosis related, it would have to link against the diagnosis that the patient didn't have that diagnosis. Say they were newly diagnosed with hypertension, I would hope, but say they are, and it would deny.</p> <p>Dr. Adma: I have seen some kids being prescribed 0.6 of Clonidine and that's a safety risk, you know. So I think it's a good idea to include those two medications.</p> <p>Dr. Moeller: I was just thinking that for adults.</p> <p>Dr. Larson: So I have the addition of those two. And also adding another row for the pediatric dosing? Is what I have indicated.</p> <p>Dr. Ellermeier: I don't know if we, that we have to do a separate for pediatrics. Maybe a separate, like.</p> <p>Dr. Millhuff: I'm thinking of below 6, is what I'm thinking.</p> <p>Dr. Porter: I think what we were talking about was adding if, going back to the child psychiatrist and maybe child neurologist, get a separate column. Wasn't that what we were talking about?</p> <p>Dr. Ellermeier: Yeah.</p>	
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	<p>Dep. Sec. Dunkel: That is something we can talk about next time is maybe some suggestions. What I'll ask the group for the next time we come, we meet, having conversations on the ones we have dose limits on. Are there other things we want to consider such as columns. Your algorithm and whether that these limits are initial dosing limits or whatever make sense. Let's nail one in place. We've got this one we're working on. Let's go ahead and have that conversation.</p> <p>Dr. Larson: I will look for feedback from the committee.</p> <p>Dep. Sec. Dunkel: So for this one, Liane will add the drugs we just talked about and we'll circulate it again for feedback on that component. And with that, I think we'll go ahead and table this one until next time if that works for everybody. I don't think there's a point where we're going to have enough time to make a really solid final draft.</p> <p>Dr. Ellermeier: I also think, perhaps, data with an age breakout would be useful.</p> <p>Dr. Smith: Just curious, like, what ages? Are you thinking 18 and under or 18 and over? Or the breakout within the kids?</p> <p>Dr. Larson: I think our general ones we've been using for the other. Not for the dosing limits but just in general, have been 2 to 5, 6 to 12, 13 to 18, 19 to 23, and 24 and up.</p> <p>Dr. Ellermeier: Well, I think that more than covers it.</p> <p>Dep. Sec. Dunkel: On the ones that go above this, if we could have it broke down by prescriber type?</p> <p>Dr. Millhuff: Liane, does 2 to 5 include 5 year olds, all the way up until you're 6?</p> <p>Dr. Larson: Yes. It includes 5 year olds.</p> <p>Dr. Ellermeier: I don't see under 2?</p> <p>Dr. Larson: We did see use in 2 year olds. We did not see any use in Zero to One year old.</p> <p>Dr. Adma: Is there a breakdown by number for 3 year olds, 4 year olds?</p> <p>Dr. Larson: I don't have it up here. Sorry, I don't have anything else on this one.</p>	
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	<p>Dep. Sec. Dunkel: Ok. So we'll work with the MCOs and our staff to get that information together. Liane will make the adjustments to the criteria and send that back out for comment. And then we'll work it again next time around.</p>	
<p>III. New Business A. Prior Authorization Criteria 2. Use of Stimulants and other ADD/ADHD Agents in Adults – Review proposed clinical criteria for adults prescribed stimulants and other ADD/ADHD agents.</p>	<p><b>Clinical Public Comment:</b> - No requests were received.</p> <p>Dep. Sec. Dunkel: Alright, we'll move on to <i>Use of Stimulants and other ADD/ADHD Agents in Adults</i>.</p> <p><b>Board Discussion:</b></p> <p>Dr. Porter: My initial concern, I think, will be reflected in number. What, for the quarter, on this criteria?</p> <p>Dr. Larson: Ok. So let's see here. For this particular one. With the criteria, I just want to state, that it would be one of these types of diagnoses; so what we had was 2,142 individuals above the age of 24 and older on a stimulant and of that, 617 had a diagnosis. So there was 1,525 that had no indication of a diagnosis that met for an approved use.</p> <p>Dr. Porter: What about the second bullet?</p> <p>Dr. Larson: For substance abuse disorder, we had 178 members.</p> <p>Dr. Porter: Is that data pulled out per quarter?</p> <p>Dr. Larson: Yes.</p> <p>Dr. Porter: So this is our biggest proposed prior authorization category.</p> <p>Dr. Larson: Since the children anti-psychotic one, yes.</p> <p>Dr. Porter: But that one wasn't really a call the doctor thing.</p> <p>Dr. Larson: And this also not a</p> <p>Dr. Porter: Oh, ok.</p> <p>Dr. Larson: Not a call the doctor, this one is to have a diagnosis within the past 365 days We were seeing a large number prescribed to adults with no diagnosis of an approved indication.</p>	<p>The criteria were tabled.</p>

	<p>Dr. Porter: One thing I want to comment. There are both controlled and uncontrolled substances on this list.</p> <p>Dr. Larson: Yes.</p> <p>Dr. Porter: I think that's where the discussion by the committee. I don't know what the problem is treating someone with ADHD with a non-controlled substance.</p> <p>Dr. Larson: I just included the list the same for all criteria as a baseline.</p> <p>Dr. Porter: And different people could argue if they think a whole year of sobriety is required or 90 days; I think there'd be different feelings about it. Hyper somnolence and DSM-V doesn't include anybody that's suffering from the effects of a sedating medication. That has to be a primary hyper somnolence by the DSM-V. So there's just quite a number of areas where these meds can be used usefully in psychiatry that I don't see has a problem. For example, it says cancer related fatigue, the first time I ran across the off label use of these was in med school was for HIV. Of course people had more severe outcomes from HIV back then but it wasn't cancer related. It was essentially helping them stay alert for their terminal time. So I just think, again, I don't know how long we're going to stay and I don't know how much I'm going to say, but those are my initial concerns. And maybe it would be covered by these proposed gold card. If people knew what they were doing, they'd be given a little slack on this, but I think these are pretty strict criteria. I would use them. I do use them for things beyond these.</p> <p>Dr. Ellermeier: So what else would you recommend adding to this then?</p> <p>Dr. Porter: Well I think that a place I found it useful, some people with schizophrenia, whose symptoms can only be controlled by a high dose of clozapine or another medication. And they're sleeping for 16 hours. Now you can worsen psychosis with these meds. So it has to be done carefully. But it allows a lot more functionality to their day. There's just a lot of niches there in odd cases where these meds can be used. People with Bi-polar disorder as an adjunctive treatment.</p> <p>Dr. Moeller: I was going to say, because we use it a lot in elderly patients for major depression. I've just seen some really good use. And we use low doses.</p> <p>Dr. Porter: It's not a FDA approved adjunctive treatment for major depression, but it's in the reasonable consideration of things to make anti-depressants work better. Depending on the category, the illness and the medical health. And so I, again, maybe this would be one if we could consider that category of gold card that if people knew what they were doing they wouldn't have to do a prior auth every time they did it. And I'm trying to speak quickly in difference to my colleagues. And those are my thoughts.</p>	
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	<p>Dr. Moeller: Yeah I thought we should expand the indications if we make it. Cause it really is restrictive. I use it a lot in depression. I would move to add the anti-depression indication. And I agree with your, we've got stimulants and do we need a prior auth, on guanfacine, and Stratters, the non-stimulants, I don't know.</p> <p>Dr. Porter: They almost would never be used in non ADHD, but they would be used in, they'd be the drug of choice for people that were addicted. It also sounds like we're being a little lazy in our diagnosing cause 2,100, you know, what, 600 have the ADHD diagnoses, probably there's some providers aren't doing the adequate documentation on some of that, I would say.</p> <p>Dep. Sec. Dunkel: So which, again, real quickly Dr. Porter, the ones that you'd recommend be removed from the list?</p> <p>Dr. Porter: Well, I would say that there's two different bullets, and I can't see why the second bullet would apply to the non-stimulants whatsoever. So do you need to have them on there at all for this criteria? Because they're also seldom used in anything other than ADHD. I never heard for some of them used for anything other than ADHD. The Kapvay, the Strattera, I guess sometimes we use Strattera.</p> <p>Dr. Ellermeier: It could also be that second bullet could also be if they do have a diagnosis of substance abuse, the only, it has to be one of those 3?</p> <p>Dr. Porter: Is that to avoid the review?</p> <p>Dr. Ellermeier: Yeah.</p> <p>Dr. Porter: I think for the committee, I would also say, maybe, I wonder if a year, if somebody's got documented ADHD, which actually can make it, and I don't want to make excuses for addiction, make it harder to function and stay, if you really have severe ADHD and it's not treated it can make you more vulnerable to your addictive behaviors. And I don't, I don't know if a year is to, seems a little long to me, maybe.</p> <p>Dr. Ellermeier: I also, I, correct me if I'm wrong, but I thought that you should be using, if you are going to use the system you should be using an extended release?</p> <p>Dr. Porter: Generally speaking an immediate release.</p> <p>Dr. Ellermeier: So maybe they can't get an immediate release?</p>	
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	<p>Dr. Porter: Again, I realize this is going to take more discussion, I just wanted to get my 2 cents in. I think it would be good to expand the adjunctive treatment of mood and psychotic disorders. And other, instead of just cancer related fatigue, other severe medical conditions. Fatigue from severe medical conditions.</p> <p>Dr. Moeller: I think severe that maybe way too broad. I don't know if there is any coding for fatigue?</p> <p>Dr. Porter: I guess end of life care? You know, I don't know.</p> <p>Dr. Moeller: I do understand the, for example, the Cloazaryl, for hyper somnolence. But I have concern about them in psychosis and in Bi-Polar.</p> <p>Dr. Porter: It certainly does say whenever you do that, it pops up an appropriate warning. That you need to be worried increase in dopamine can increase the very symptoms that you mention. It's any number of patients that it's a useful treatment. That you're monitoring for that.</p> <p>Dr. Moeller: Yeah, I just thought fatigue, you know, we had a patient, that was like on 3 different sleep aides and then had to have a stimulant to wake him up. Hopefully this thing would catch that. I don't want fatigue to be too broad.</p> <p>Dr. Porter: Right. Maybe this gold card thing would cover some of the situation. People that are doing it are safe to do it and do it in the proper way.</p> <p>Dep. Sec. Dunkel: We've had some conversation. With additions, do we want to keep moving forward on this? Or do we need to table and hold off until?</p> <p>Dr. Millhuff: I guess we'll see the draft and look over it. I agree with what Ty just said. Word for word.</p> <p>Dr. Larson: I will just need those specific indications the committees wanting to include.</p> <p>Dr. Moeller: I don't know, maybe depression or current depression? Is there a code for treatment resistant depression?</p> <p>Dr. Porter: It's not an ICD-10 code, if you're going by that, you'd probably go recurrent would capture some of that.</p> <p>Dr. Moeller: It wouldn't be used in a single episode?</p> <p>Dr. Larson: So, recurrent depression?</p>	
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	<p>Dr. Porter: Yes.</p> <p>Dep. Sec. Dunkel:</p> <p>Dr. Adma: There's a code for vegetative depression.</p> <p>Dr. Moeller: Yes.</p> <p>Dr. Adma: That's what we're talking about, so.</p> <p>Dr. Moeller: Probably recurrent.</p> <p>Dr. Porter: I guess, do we say bi-polar depression? Because they are bi-polar but they are in a depressed phase and that's a medicine you can pretty easily get in and out of a person's system as opposed to some of the anti-depressants. It's not indicated for either one but it is used for both.</p> <p>Dr. Adma: I think that the depression covered it. Whether it be Bi-polar or depression. As long as it says depression.</p> <p>Dr. Larson: So, just leave it as Depression?</p> <p>Dr. Moeller: When you say they have a documented diagnosis is it a documented diagnosis within the last two years?</p> <p>Dr. Larson: Yes. Oh, I'm sorry, I was thinking about the other one. Yes, they would have an documented diagnosis. I am sorry I didn't include it in that, as I did in the one below, for the length of the approval so even in the previous 365 days.</p> <p>Dr. Porter: You go by what they submit on the bill? Like an individual comes in and they are being for major depression, and you got meds for that and then they also have ADHD, the physician usually put one code on the bill. So we submit a MDD code, but their ADHD is on their chart but not on the billing code.</p> <p>Dr. Larson: We would only have access to the information which was sent across.</p> <p>Dr. Porter: On billing codes?</p> <p>Dr. Larson: With, yeah but the other thing is, it doesn't necessarily have to be that billing code it was whatever was billed over the previous year. I know when we pull our information; it was able to see the different diagnoses over the previous year.</p>	
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	<p>Dr. Porter: Many patients you might see that you may have never coded the patients ADHD over the year.</p> <p>Dr. Larson: But then if that was, if not of these met on none of these that were sent across, correct if I am wrong MCO's, but they wouldn't have any way to bump that information against the diagnosis code so it would come back as a PA.</p> <p>Dr. Porter: But that one you might be able to send, this one isn't a health plan call. That one we might be able to send.</p> <p>Dr. Larson: That would be denied at pharmacy if there wasn't.</p> <p>Dr. Ellermeier: And there would be a form to complete saying.</p> <p>Dr. Larson: That they had that diagnosis.</p> <p>Dr. Adma: It could be a primary or secondary diagnosis?</p> <p>Dr. Smith: Sure.</p> <p>Dr. Klingler: A kid comes in for a well child check, I would code that, there secondary diagnosis is ADD med check. Is that going to flag that they have an appropriate diagnosis? If it's the secondary diagnosis on the bill?</p> <p>Dr. Smith: Yes. Yep, any diagnosis is how we've looked at it in the past but we can change those.</p> <p>Dr. Porter: Is this related? Amerigroup, at least, just started asking for the diagnosis on some prescriptions, on the actual prescriptions itself.</p> <p>Dr. Moeller: I know it's not required by the board anymore but doesn't Medicaid still require it on Adderall? To put the indications? Some people have told me that.</p> <p>Dr. Smith: It's still in the pharmacy program manual from like, 2000. Maybe Nancy knows.</p> <p>Dr. Porter: No what I meant to say was, at least one of the MCO's recently started asking for the diagnosis on all prescriptions. So I don't know if that data would be useful? Cause then if you saw somebody for MDD, and you gave them a script for ADHD then it would be on the script. Oh' I don't know what other purposes it would be, that would be, it might, that might capture that also, what do you think?</p>	
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	<p>Dr. Larson: There is at the point of sale you can enter in, but in terms of this, it would be required to be in the medical claims information and not just being put in at point of sale. I'll be honest, as being a pharmacist, a lot of times they know what code needs to be put in if it's on the prescription or not, it will get entered at the point of sale.</p> <p>Dr. Millhuff: How do you know if the if the patient has got a psychiatric assessment, the only way you can know when it has been billed in the past? Because what I am worried about is all the people getting these stimulants that don't have you know the most widely, wide reason you prescribe these medicine's would be for ADHD in terms of the prevalence and I am worried the numbers are just gave a lot of people are just getting this without an adequate moderation, how do we make it a little more tighter than that?</p> <p>Dr. Moeller: I wonder if we should say for the depression, because I know, when you're right, because when you are reading this, I mean, this is for you don't have to be a psychiatrist, you have to write this.</p> <p>Dr. Ellermeier: That's for kids.</p> <p>Dr. Moeller: Yeah' for adults, the primary care doctor can write a stimulant but it has to be approved for these indications. And you know back to, you know what we were talking about for like depression, maybe that should be a sub-bullet? Psychiatrists, because I want to know, I do.</p> <p>Dr. Klingler: What your saying is, we will get someone to transfer into our group and the by the way I need my medication refilled. Well we say we can't refill it more than 30 days unless we go back and look at it, how you were diagnosed. And sometimes it's you know' oh teacher says he's hyperactive in school, diagnosis ADD. Well that doesn't meet the DSM criteria. And I think what you're saying is somewhere does it needs to be documented that appropriate evaluation using appropriate tools and history was obtained. Rather than just throwing it out cause oh' mom says he's hyper let's give him meds.</p> <p>Dr. Porter: I think the data we are looking at, we only know of the 2100 adults over 24, ADD meds, we only know, that 600 of them had also submitted an ADHD code. That showed up.</p> <p>Dr. Larson: Or narcolepsy, or binge eating.</p> <p>Dr. Porter: Or this. So, then again I would say my practice that wouldn't be that surprising a fair amount of, I see a few adults for primary ADHD and that's it. And quite a few where it's the secondary or tertiary diagnosis. It wouldn't necessarily show up.</p> <p>Ms. Cobb: I guess that is a big difference in primary care, where they say it's going to be ADD there. Where a tier might be beneficial.</p>	
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	<p>Dr. Ellermeier: So perhaps there is another goal? I think that is what we are saying. The primary care prescribed for any of these, and then a specific practitioner set can prescribe for a more broader set of indications.</p> <p>Dr. Larson: So kind of an either/or? The primary provider can prescribe for these or the medication can be prescribed by a psychiatrist.</p> <p>Dr. Ellermeier: For a broader set of indications.</p> <p>Dr. Larson: Would there be a set of indications? Or no limits if it's a psychiatrist prescribing it.</p> <p>Dr. Porter: We still have the dose limits right?</p> <p>Dr. Larson: Yes.</p> <p>Dr. Moeller: So what are we trying to restrict? The rational? Just inappropriate use? I mean, well I wouldn't want a psychiatrist prescribe for weight loss, so I guess that is where the comment psychiatrist then could maybe say excluding weight loss.</p> <p>Dr. Shoyinka: One thing I see a lot, particularly kids in PRTF, is that you get these kids diagnosis with ADHD and when you dig a little deeper it turns out that they have some sort of actual disability. It's possible to have both but it's kind of, in the one condition kid gets better, in the other condition the kid gets worse and it sort of perpetrates a cycle. It's just something to add into the discussion.</p> <p>Dep. Sec. Dunkel: We will go ahead and break it apart and we'll have, either has to be prescribed by some of the same grouping we had, psychiatrists, neurologist, and behavioral developmental pediatrician.</p> <p>Dr. Larson: This will be for the adults.</p> <p>Dep. Sec. Dunkel: Oh that's right, forget the pediatrician in this one.</p> <p>Dr. Larson: I can send this one around to the group as well for work during the in between.</p> <p>Dep. Sec. Dunkel: We'll go ahead and draft that up with the suggestions. Look at the other group of prescribers and some of other things that will fall in here for the list. You guys can forward any suggestions you have for that list to Liane so she can incorporate it. And then we'll revisit it with those additions next time.</p>	
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<p>III. New Business</p> <p>A. Prior Authorization Criteria</p> <p>3. Use of Stimulants and other ADD/ADHD agents in children – Review proposed clinical criteria for children prescribed stimulants and other ADD/ADHD agents.</p>	<p><b>Clinical Public Comment:</b> - No requests were received.</p> <p>Dep. Sec. Dunkel: One more and; we have one public comment today?</p> <p>Dr. Larson: Yes.</p> <p>Dep. Sec. Dunkel: Use of Stimulants and other ADD/ADHD agents in children. Ages 3 and younger.</p> <p>Dr. Larson: So this is criteria, I'm using the same exact list as for the others. For ages 3 and under must be prescribed by or in consultation/collaboration with a psychiatrist, neurologist, or developmental behavioral pediatrician, and if not than a peer-to-peer consult with a health plan psychiatrist, medical director, or pharmacy director, must be completed for approval. So at this point, it's presented as a two tier just as a starting point, could be either/or or left as a 2 tier, or any changes the committee would require.</p> <p><b>Board Discussion:</b></p> <p>Dr. Ellermeier: How many?</p> <p>Dr. Larson: We had 33 children.</p> <p>Dr. Millhuff: What ages? 3 and?</p> <p>Dr. Larson: 3 and below. I have; let me see if I have; here's the breakdown. Let me see if I can make this; I also did 4 and 5 just to give an idea. So we had 3-2 year olds, 30-3 year olds, and above, just for information, 153-4 year olds, and 603-5 year olds.</p> <p>Dr. Ellermeier: So what we're saying is it would have to be a specialist and they would have to have a consult.</p> <p>Dr. Larson: As it's presented currently. For 3 years and under.</p> <p>Dr. Klingler: I guess my thought is that it would just have to be a specialist and that we would remove the second bullet point.</p> <p>Dr. Millhuff: I would agree with that.</p> <p>Dr. Moeller: Should it be a child psychiatrist?</p> <p>Dr. Porter: Yeah, not an adult psychiatrist, yes.</p>	<p>The criteria were tabled.</p>
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	<p>Dr. Klinger: And pediatric neurologist too.</p> <p>Dr. Moeller: Change it to pediatric.</p> <p>Dr. Ellermeier: Yeah, I think if we're going to remove the consult.</p> <p>Dr. Larson: So I have child/adolescent psychiatrist, pediatric neurologist, or developmental behavioral pediatrician.</p> <p>Dr. Millhuff: Right.</p> <p>Dr. Larson: Ok, and leave everything else the same?</p> <p>Dr. Adma: What about western Kansas? Where there's no child/adolescent psychiatrist?</p> <p>Dr. Klinger: I think a 3 year old needs to be referred to someone that's appropriate to care for them.</p> <p>Dr. Porter: Now a thing might come up where they've been sent to a center, Mayo or KU, and they've been told that they should be on this; that western Kansas doc should be able to continue as recommended?</p> <p>Dr. Larson: Yeah, and as it is currently written, it would be with: in consultation/collaboration with, so that will allow for an individual not listed to prescribe if it had been in consultation with one of those that is listed.</p> <p>Dr. Adma: Ok.</p> <p>Dr. Millhuff: Yeah. I was thinking about this in our last conversation. This is, again, getting back with Texas guidelines they say, one of their first bullet is "That a review is triggered if there is an absence of a thorough assessment for a DSM-V diagnosis in the child's medical record." It just seems like the person in western Kansas; I've worked them up; they've got my record and, you know, they're following suit; they come back to see me when they are having more trouble. I'm just wondering how these guys, in a review process, can see that a thorough psychiatric assessment has been done. It's just a comment that, as I think, we're putting these together.</p> <p>Dr. Larson: The only thing I can think of is, I don't know, if that's billed, would you be able to see that?</p> <p>Dr. Mack: In the coding type, yes.</p>	
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	<p>Dr. Millhuff: If that is in the history, I think that helps to substantiate the reason for the use of these medicines whether they're little kids or adults.</p> <p>Dr. Porter: Does it capture; would an inpatient hospitalization show up adequately to check that box?</p> <p>Dr. Mack: Without getting the exact records we wouldn't be able to tell if ADD/ADHD was specifically assessed as part of the evaluation, just based on the code.</p> <p>Dr. Porter: I will say for, usually ADHD evaluations aren't the major part of a child hospitalization. I don't know, but I'm sure it comes up at times.</p> <p>Dr. Adma: It does come up. It does come up that kids are diagnosed in the hospital.</p> <p>Dr. Mack: If the diagnosis code for ADHD comes through, then yeah, just the billing codes.</p> <p>Dr. Smith: Because you cannot admit for that code. It's never.</p> <p>Dr. Porter: For ADHD?</p> <p>Dr. Mack: Yes.</p> <p>Dr. Porter: Ok. I stand corrected.</p> <p>Dr. Adma: That may not be the only diagnosis.</p> <p>Dr. Ellermeier: We're currently talking about only 33 kids. I don't feel that uncomfortable about making them go through this process. I think the safety far outweighs the burden.</p> <p>Dr Moeller: And I think they're the most at risk population.</p> <p>Dr. Adma: What are the numbers now, in terms of the breakdown of the 33 kids, 3 or older or younger? What is the breakdown in terms of the prescribers?</p> <p>Dr. Larson: I don't have that information.</p> <p>Ms. Murff: I have that for our plan. We have, of the 33 that are 3 and up, we have 11. We had 4 that were psychiatrists, 5 that were nurse practitioner psychiatrists, 1 that was a family practice MD, and 1 that was a family practice nurse practitioner. I had one of my 11 that didn't have a diagnosis on file, the other 10 did.</p>	
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	<p>Dr. Klingler: That's good information.</p> <p>Dr. Adma: So none of them were child psychiatrists of the 11? And how many of them were rural Kansas?</p> <p>Ms. Murff: Well, you know that, I wish, I actually probably did put it in my spreadsheet but, no, they weren't all rural. You know that just didn't stick out in my mind as much as just, you know, the age.</p> <p>Dr. Adma: At some point, what do you think about the 4 year olds? Well, one place to start?</p> <p>Dr. Moeller: It will be a lot harder for 4 year olds.</p> <p>Dr. Ellermeier: 153 more.</p> <p>Dep. Sec. Dunkel: So for bringing back around next time for a final vote; are we ok with this language on this one?</p> <p>Dr. Ellermeier: I think we decided to remove the peer to peer consult.</p> <p>Dr. Moeller: And add pediatrician.</p> <p>Dr. Klingler: And add pediatric.</p> <p>Dep. Sec. Dunkel: With the amendments that have been discussed.</p> <p>Dr. Larson: Yes. I have the addition of child/adolescent psychiatrist, pediatric neurologist and removal of peer-to-peer consult.</p> <p>Dep. Sec. Dunkel: Any objections to that?</p> <p>{Silence}</p> <p>Dep. Sec. Dunkel: Then we will have it drawn up as a final action type of piece next week, which is the only one we got that far. But really, I would like to thank everyone for the conversation. I think that the conversation around the gold card and conversations are all the good pieces; this is really what I, when we first talked about having these meetings, this is the conversation I was hoping to have. Even, again, point out places where here's kind of a strong man and you guys saying that doesn't address all the issues and so we appreciate the time and thought. We'll keep pushing things until we get it to where it is comfortable and right.</p>	
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	<p>With that, the DUR approved criteria timeline under the Process Improvement Initiatives, we'll go ahead and send that out to you. I kind of alluded to it earlier. We're looking at some things starting May 1st and then rolling out for the next 4 months, would be for May, June, July, August. But we will send specific information to you guys to look at and give feedback on around that.</p>	
V. Open Public Comment*	<p><b>Public Comment:</b> - Request received from Janie Huff from Takeda Pharmaceuticals.</p> <p>Dep. Sec. Dunkel: With that, I go ahead and open up public comment. We had one request received, and that's from Janie Huff from Takeda pharmaceuticals.</p> <p>Ms. Huff: Yes, Hi. I'm Janie Huff and I have with me Jeff Neshi. He's are our health outcomes liaison Pharm.D. and we just wanted to disseminate an article that was very timely since you guys are in the process or already have been managing this class. So I will just let Jeff do some quick comments.</p> <p>Dr. Neshi: Sure. I'll be real quick, because I am assuming that some of you have tickets to that game over in Lawrence here. I'm probably the only person in Denver that wasn't at the parade today. I think there are 5 ½ million people in Colorado apparently about 1.3 of them were downtown today. My son was very disappointed that we weren't one of them.</p> <p>So, quick article, I know that its germane to the discussions you talked about, implementing step criteria, prior authorization, had to make formularies. This is a recent article that came out and I think an avenue for discussion. I've seen a lot of state Medicaid's about, what are the effects of putting some of these formularies, prior authorization outcomes, restrictions. Obviously, intuitively, on paper they look like they make sense. But then you were talking about, that's a lot of phone calls, that's a lot of work, prior authorizations cost money. Step therapies cost money, both administratively and to the patient.</p> <p>So have we studied the literature? Have we seen the outcomes? So, lot of data out there in terms of if you look at the NSAIDs back in the 90's, ACE's ARB's. We have looked at TINA optim inhibitors. But, actually, in depression, we really haven't seen a lot in terms of real claims data. So this is nice. This is Medicaid claims data. 24 states. Kansas is not one of them, but there are 24 states. A little over nine hundred thousand patients that they looked at. It's a Medicaid claims data base. They wanted to look and see and they used, basically, the states as their own control. Prior to implementing PA's or step therapy, and then afterwards. They wanted to get a look at patients with a MDD diagnosis, an ICD-9 code. You know, 1 outpatient or 2, in patient claims per year. Did we see an increase in overall costs and MDD costs? Looking, basically, at inpatient hospitalization, utilization of services, and pharmacy.</p> <p>So, bottom line is, I'm just going to show you the nine hundred thousand patients, I looked in there and actually patients when you put in the steps, excuse me a PA, I saw about a 6% increase of cost, then the step plus the PA was around 16% . Obviously your MDD population and Medicaid I think is probably a sicker population than you see in private insurance. So I think you know its typically the MDD is around 20% Medicaid patients vs. around 6 of private insurance. But, interestingly, about 10-15 % of patients actually put</p>	

	<p>in a step for privatization don't even fill that initially script or depending on how they come in and their criteria coming in and obviously from the last two and ½ hours, it's very difficult to develop these. Do you have what is called replication of failure? Some of these others already failed that first drug, go through and do it again, or do it a second time. So, again, some of these things, these unforeseen costs in these patients for unforeseen side effects again, they failed therapy or, or if they have to go to that second or third one they just give up. I'm not going to go through that. It's a Friday night and in western Kansas and can't my PA filled, and can't get the hospital, you know, to my pharmacy to get my drug and end up in the hospital over the weekend again, so just food for thought, I would like you take over this article but it is some interesting and we actually looked it's not a model, you know I am a pharmacist and an economist we do model a lot this is actual claims data uh' so take a look at it, there are some limitations obviously many times manufacturers; which is my company which do contracts you know our rebates none of that was factored into the cost here. Many of the off label uses, many of these drugs have off label usages. This was trying to look at a pure MDD population. And, again, something to think about is some of these are not as black and white as they seem. Some of the data, at least in the study here and there are some you can replicate in others, have shown really many times you tend to see almost an increase in use of other medical services that you don't see in often in savings in drugs. So, I will stop with that and appreciate your time and that if you do have any questions, that I might see you at your May meeting. Thanks for your time.</p> <p>Dep. Sec. Dunkel: Thank you.</p> <p><b>Board Discussion:</b></p> <p>Dep. Sec. Dunkel: Anyone else have any other comments or anything else they would like to add?</p> <p>{Silence}</p> <p>Dep. Sec. Dunkel: Well, thank you guys for spending an additional 35 minutes with us. We'll fall back and get some additional information out. And again, thank you all.</p>	
VI. Adjourn	<p>Dep. Sec. Dunkel: With that, we'll adjourn.</p> <p>Adjourned 4:36pm</p>	
<p>*Clinical and open public comment requests and written testimony must be submitted one week prior to meeting to llarson@kdheks.gov. If providing clinical comment, please indicate which agenda item you are requesting time to comment. Time limits during period of comment will be determined based on number of requests received.</p>		